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## CLINICAL LECTURES.

### DOUBLE OÖPHORECTOMY FOR DISEASE OF BOTH OVARIES AND MULTIPLE UTERINE FIBROIDS.[1]

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REPORTED BY LEWIS H. ADLER, JR., M. D.

*Gentlemen:* This is the last clinic I shall deliver before you this session. I so much prefer this method of teaching to didatic lectures that I can truly say that I enjoy clinics and am really sorry that they are over.

Last week I had this woman before you just at the close of the lecture, and, as the case may have slipped out of your minds, I shall briefly run over it again as well as my diagnosis, in order to see how near I was right. She is a colored woman, forty-seven years of age, and has borne nine children. Since the birth of her last child—which was a premature birth and occurred one year ago—she has noticed an enlargement of the abdomen together with pain and uterine hemorrhage. She denies specific disease at any time of her life, and so far as she knows has never had peritonitis. Before she insisted so strongly upon these two facts, the question very naturally came up in my mind: Can she be suffering from a blenorrhagia due to some specific infection about the time of her delivery, which occasioned a subsequent septicemia and infection of the glands in the pelvis? Such a condition would not be impossible; but taking into consideration her race, age and history, I was led to consider this a case of multiple uterine fibroids together with diseased and adherent appendages.

While my assistants are preparing the patient, I may mention that the case upon which I last week performed before you this same operation, but for cystic ovaries, has done well from the first, the temperature at no time having gone above 100.2° Fahr. I am truly sorry that for want of time I have not been able to deliver before you this year a didatic lecture on the subject of the ovaries and tubes; but anyhow, to-day the idea that I want to leave uppermost in your minds is that pain in the abdomen, occurring about a week before the menstrual periods, generally indicates tubal rather than ovarian trouble, and that these chronic troubles of the appendages are, as a rule, the results of the exanthemata or of gonorrhœa. These girls—for more frequently they are girls or very young women—are generally emaciated, but not always; for ovarian disease, like fibroid tumors, is often accompanied with corpulency. They are great sufferers, hyperæsthetic and nervous, and often have to be examined under ether.

Returning to the case before us to-day, you will notice that the lineæ albicantes are markedly visible; such a condition in this instance is due to the stretching of the abdomen from her frequent pregnancies.

I now cut boldly down through the fat and the superficial fascia and find the linea alba, which is readily recognizable by its appearing like a yellow line between the two recti muscles. After going through the deep fascia, I come to the second layer of fat, beneath which lies the peritoneum. Before opening this latter serous membrane, I control all bleeding points with catch forceps.

I now pick up the peritoneum with a pair of forceps and gently cut through it, taking care not to wound any stray loop of intestine; now on inserting two fingers in the opening made, I am enabled by means of a pair of blunt-pointed scissors to enlarge the

[1] Delivered at the University Hospital.

wound to the required extent. I am now in the abdominal cavity and there find that in addition to the multiple uterine fibroids, numerous intestinal adhesions by which the left ovary is firmly bound down, and that the tube is the seat of a cyst, which, in spite of all precautions, burst during the process of its removal, emitting a tarry fluid which greatly increases the danger of peritonitis. The ovary, being firmly bound down to the womb, will require some handling to have the adhesions broken loose, and for this reason I have no hesitancy in making the incision larger, so that I can the more easily see what I am doing.

As the pedicle is hard to get at, I secure it with a surgeon's knot, after which the ovary and tube are removed.

Upon examining the right side, I break up many adhesions and find that the right ovary is fastened down by these bands, but not so firmly as was the left organ. It is also diseased, and I shall proceed to tie its pedicle and remove the appendages as I did on the opposite side. As the cyst on the left tube burst during my manipulations and its contents escaped into the peritoneal cavity, I now syringe out the abdomen and keep on repeating this process until the water returns clear and all the fragments of loose tissue and blood clots are floated out. This case is pre-eminently one for a drainage-tube, both on account of the large number of adhesions and the escape of the tarry fluid from the tubal cyst. In other words, this was a bad case, yet it was easy in comparison with some that are done here; as, for instance, it was but a few weeks ago that I performed here in the hospital this same operation upon a patient in whom the disease had existed not for only one year, as in this case, but for twenty-two years. Yet she recovered all right, so that my prognosis in the present case is good, as the adhesions were not so appalling and there was no wound of the intestines, which would have been recognized by the escape of their contents into the cavity of the peritoneum with a consequent perception of fecal odor.

I now thoroughly drain the abdomen of all fluid and proceed to close the incision; before doing this I place a clean sponge in Douglas's pouch, another in the sulcus between the bladder and the womb, and a third (large, broad and flat) over the intestines under the wound to catch the blood that may ooze from the cut surfaces.

Each thread has a needle upon each end—which allows it to be passed from within outwards. Each needle is inserted about a quarter of an inch away from the edge of the wound, and it is well to include in the sutures all the layers of the parieties—cutaneous, muscular, aponeurotic and peritoneal. I would lay especial stress on including the muscular layer, because many ovariotomists think that by so doing, recti muscle abscesses are apt to follow. But it seems to me that it is better to run the risk of a stitch abscess than the more serious and grave one of ventral hernia.

Having inserted all the sutures, I remove the sponges previously placed in the abdomen, and am rejoiced to find that there is but little blood on them; for this tells me that there is scarcely any bleeding either from the sutures or from the abdominal cavity itself. I now count my sponges and instruments, and, as the number is found correct, close the incision, leaving the drainage-tube *in situ*.

My method for closing the wound is by grasping in one hand all the sutures on my side, while my assistant does the same on the opposite side, when the edges of the wound are brought firmly together, and at the same time all the air is expelled from the abdominal cavity. Each suture is now tied with the surgeon's knot. The entire wound, excepting the portion occupied by the drainage-tube, being closed, the ends of the sutures are gathered together and cut off several inches from the knots. After sprinkling iodoform over the wound, especially into and around the umbilicus, I put over it several layers of gauze previously soaked in a 1-2,000 solution of the bichloride of mercury, and next two inches of baked cotton. But, in this instance, the drainage-tube is too long, so I cut an opening immediately over it through the cotton and the gauze, so that the tube, instead of being pressed down on the intestines, protrudes through the opening, and, having secured around it horizontally a small sheet of india rubber, I fix it in position either with safety pins or by passing some of the adhesive rubber strips—which are always used to hold the layers of cotton and gauze in place—close under the nozzle and over this I pin with safety pins the flannel binder smoothly around the abdomen. From this protruding tube the accumulating exudations will be sucked up, at first, every one-half hour and later, every hour or two hours as the case may demand. This is done by the nurse

by means of a special syringe, antiseptically prepared, which is to be thrown away when it ceases to be used in this case.

The drainage-tube will probably be removed in twenty-four hours or certainly in forty-eight hours, and, in the meantime, it will be turned on its horizontal axis by the nurse every 6 to 8 hours, in order to prevent its being sealed to the surrounding tissues by plastic exudations or from its exerting too long a pressure on one spot.

I have sat for hours beside patients in this condition, waiting to decide whether or not to re-open the abdomen and secure bleeding vessels. I spent last Thanksgiving Day, thus occupied, after the removal of a tumor which had been in existence nine years and which weighed ninety-four pounds. Fortunately the patient recovered without any additional operation.

The after-treatment will consist in keeping the patient still, on her back, and without food for twenty-four hours; no opium either, unless the pain becomes too excruciating, which is very rarely the case. The objections to opium are that it checks both secretion and excretion and tends to nauseate. Hot cans will be applied to the body, care being taken that they do not come in too close contact with the skin, as the burns which they make are unusually severe. She will be allowed to see no one for some days but the physician and nurse, as absolute quietness must be observed.

Should obstinate vomiting occur, ice will be given or sinapisms applied to the epigastrium. If there is much flatulence, it will be relieved by inserting a flexible catheter high up into the rectum or by enemata of turpentine, soap and water. As a rule it is necessary to catheterize for a day or so after the operation, but it is to be avoided if possible, as the too-frequent use of that instrument is likely to cause an irritable bladder that is slow to respond to treatment.

On the second day we will give half an ounce of milk every two hours, increasing the quantity gradually as her condition demands. If her temperature should prove high, 101° or over, ice will be applied to the head, the body sponged, a saline cathartic given or some antifebric remedy administered. On the fourth or fifth day the bowels will be freely opened with castor oil or the compound licorice powder purge. If these fail to act they must be supplemented by an enema.

In from a week to eight or nine days, the dressing now put on will be ready to be removed and the stitches taken out. The wound will first be washed with some antiseptic solution, then with alcohol, after which the stitches will be removed, and the abdomen rewashed and dressed as before, but with the addition of adhesive straps over the skin and wound, to strengthen the union already existing. To prevent any possibility of hernia at the site of the wound, the patient is kept in bed from two and a half to three weeks, and then for months has to wear some kind of a close-fitting binder or abdominal supporter. I may state that some ovariotomists are opposed to this long wearing of the binder, one of the principal objectors being Mr. Frederic Treves, a London surgeon, who states that by an over-prolonged use of an abdominal support the parietes are weakened, and thinks that the secret of success in preventing ventral hernia is not to allow the patient to get out of bed too soon—a month or longer not being an unreasonable time.

I will conclude my remarks with a few words upon the subsequent dangers of ovariotomy. Those which are likely to occur are collapse, hemorrhage, septic poisoning and peritonitis.

Collapse usually occurs immediately after or during the operation. The treatment has already been alluded to in sufficient detail. Hemorrhage, when internal, will require the wound to be reopened and the bleeding vessels sought for and tied. Septic poisoning is indicated by a frequent pulse, an elevated temperature, feebleness, mild delirium and, at times, marked chill. The treatment is a brisk saline cathartic and the administration of large doses of quinine. This complication of the case, as a rule, ends fatally. Peritonitis is the greatest cause of the mortality in this operation. The symptoms are well known: a wiry pulse, extreme abdominal tenderness and distention, etc. The prognosis in a case of peritonitis complicating ovariotomy is not usually grave. Saline cathartics, poultices over the abdomen and stimulants are called for, and is the treatment usually pursued.

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—Camphorated naphthalin has been recommended by L. Keutmann, the camphor concealing the disagreeable naphthalin odor. It is prepared by melting together the two ingredients in the proportion of one of camphor to four of naphthalin.

# DIABETES MELLITUS AND DIABETES INSIPIDUS.—CHRONIC BRIGHT'S DISEASE.

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## Diabetes Mellitus and Diabetes Insipidus.

*Gentlemen:* I want to show you first this morning, a case of diabetes mellitus, upon which I delivered a systematic lecture last week. The special reason I have in bringing this patient before you this morning, is to let you see in her case the result of the milk treatment, and to teach you what I regard as its true position. It cannot be regarded as a cure. On the other hand, the glycosuria is often greatly reduced by it. Let me remind you again at the outset, that the milk used should be skimmed milk; exactly why I am unable to say, as fat, which is almost alone removed in the skimming, is usually well assimilated by diabetics.

While this woman was on the milk diet she improved in several particulars: The amount of urine voided decreased daily, although the actual quantity of fluid taken into the system was increased. Thus, before she began the milk diet the amount of urine passed daily increased gradually from three hundred and ninety to four hundred and forty ounces in a week's time. The amount of sugar passed was two and a half per cent., thus averaging over nine ounces; and she was getting worse and worse each day. When she began to take the milk, the amount of urine gradually decreased from four hundred and forty ounces a day to one hundred and two ounces a day. Up to the end of the first week, however, the percentage of sugar increased from two and a half per cent. with the four hundred and forty ounces to five and seventy-five hundredths per cent. with the one hundred and two ounces. Yet, calculating in these two instances the actual amount of sugar passed each day, we find that the quantities were nine ounces before the milk diet as against five ounces with the milk diet; the amount of sugar passed during the week under the milk diet decreasing about thirty-three per cent. or over three ounces. So much for the first week.

Later we find that she passed during the day as little as eighty ounces of urine with only one and sixty one-hundredths per cent. of sugar, thus giving a decided decrease both in the actual and relative amounts of the sugar as well as an actual diminution in the urine voided. Let me here warn you, however, that this fall in the actual amounts of urine and sugar does not take place each day progressively. On some days there was no fall at all in either from the preceding day; on other days the fall was in only one, and in others there was an actual increase, in one or both, over the amounts passed on the day before. Why this was, I am not yet prepared to state fully.

In the meantime while she has been on the milk diet she improved in every respect except her disposition, and in this is the great difficulty with the majority of diabetic patients, namely, that they are unwilling to continue this treatment for an indefinite time.

This being the case, she will have to be put on a diet consisting principally of meat and eggs, together with fruits and vegetables, care being taken to avoid starchy substances as much as possible in the two latter classes. She will also take some medicines, and the combination which I am now mostly using is antipyrin and the bicarbonate of sodium, fifteen grains of the former and thirty of the latter, three times a day, before meals. At the present time the French school is highly recommending antipyrin. I have found it useful in a few cases, especially in combination with the soda, but as yet my experience with them is rather too limited to know exactly what relative value to attach to each one of these remedies in this combination, as the alkalies themselves have long had a reputation in diabetes. As soon as the patient was put on the mixed diet the amount of urine increased from seventy and eighty ounces to as much as one hundred and one hundred and forty ounces a day, the percentage of sugar also ran up. Another point of practical importance is the fact that while under the milk diet and consequently taking more liquid than when on the mixed diet, the amount of urine passed during the twenty-four hours was less. If this fails to be the case, you may put it down to the fact that, from some unexplained reason, the milk diet is a failure in that particular case.

While I am of those who do not believe glucose is a constituent of normal urine, I believe there may be sugar in the urine for a short time and yet the patient not have

diabetes mellitus. In order to prove the presence of diabetes mellitus the urine must be passed in abnormally large amounts and contain sugar continuously. The larger the amount of urine, provided no other real disease of the kidneys be present, the lower will be its specific gravity. This is strikingly shown in hysteria, during the watermelon season, and in some cases of Bright's disease. When the amount of urine ranges from one hundred ounces to ten pints a day, being white in color and of a specific gravity of from 1.001 to 1.004 and the patient has much thirst, but no sugar, we have what is called diabetes insipidus. Though the symptoms in this are not as annoying as in diabetes mellitus, yet the wear and tear on the system caused by the thirst and frequent micturation are enough to make the person thin and nervous. Interstitial nephritis often is marked by its subject passing as much as from sixty to seventy ounces of urine a day, but never the large amount above mentioned.

The pathology of diabetes is not well understood. There is still doubt whether it is a disease of the chylopoietic system or whether it is primarily a disease of the nervous system. It is presumably not a disease of the kidneys as so many suppose. It is well known that puncturing the floor of the fourth ventricle at a certain point will be followed by polyuria and the appearance of sugar, and that the puncture of this same floor of the fourth ventricle two lines above the location of the former puncture will be followed by polyuria, but no sugar. Hence it is agued that the symptom of polyuria, whether or not accompanied with sugar, is the result of a disease of this part of the brain. But the matter is as yet involved in obscurity.

In diabetes insipidus the patient should drink water in moderation, as it is at once useless and unnecessary to keep it away from him. Of drugs, opium, in one form or another, controls the polyuria of diabetes insipidus as it does of diabetes mellitus; but it is not always necessary, and its use should be deferred until the other remedies have been tried. The other remedies now commonly used are ergot and valerian—say from a half to one and a half fluid drachms of fluid extract of ergot, or two to four fluid drachms of the elixir of valerianate of ammonia three times a day after meals. Ergotin, which is simply a concentrated and purified extract, may be used in from three to five-grain doses, and the valerianate of zinc may be given in pill form in lieu of the liquid preparation.

### Chronic Bright's Disease.

A systematic lecture was delivered on this case last week. I bring the patient before you to-day, merely to make a few remarks on the pathology of Bright's disease, and the differentiation of the different varieties from each other. I shall not attempt to fully go over her symptoms; because you remember that her history was imperfect—a fact that is often found in persons of the lower class—and also because you will recall that at the time of her admission her mind was not clear, probably because of beginning uremia. She had scarlet fever some years ago, and has been troubled with winter cough for some years. A week before her admission she took cold, but did not think anything of it. She went to bed and awoke the next morning having become suddenly blind. A symptom like this should always make you examine the urine, and this was done as soon as she was brought to the hospital. It was found to be full of albumin; but there was no dropsy, and no tube casts were found. Dr. de Schweinitz examined the patient's eyes and found that there was albuminuric retinitis present. Since then she has not done well, though she has been in bed and every care has been taken. Her symptoms point to the fact that she has had this disease for a long time and that this sudden exacerbation of her condition is a premonition that the end is near. The absence of casts in the urine does not lessen the gravity of the case. On the other hand, it is a reason for fresh anxiety. They may be retained in the uriniferous tubules, increasing the difficulty of secretion. In cases of this kind I have found at the autopsy the tubules literally packed with hyaline, waxy and epithelial casts. Although the presence of albumin in urine is justly regarded as a much less serious symptom than formerly, I think it may be said that urine containing a large quantity of albumin, not due to pus or blood, may be said to mean Bright's disease, even if no casts are found.

The different kinds of chronic nephritis are distinguished from one another by the general symptoms as well as by the chemical and microscopical characters of the urine. Much albumin points to parenchymatous nephritis. Slight albuminuria and polyurea are generally associated with chronic inter-

stitial nephritis. In the former disease when sudden blindness occurs it is generally the result of an amaurosis, caused by a sudden uremia, and the person may recover; but when the blindness comes on slowly even although it may be suddenly increased, as in this case, it is more apt to be due to the choked disc of chronic interstitial disease, and, as a rule, indicates that the end is not far off. Again, hypertrophy of the left ventricle may be present in both the parenchymatous and the interstitial varieties of the disease, but in the former it occurs late. In the latter it is, by some, regarded as a part of an affection of the vascular system, shared by heart and kidneys alike. In this case the hypertrophy is pronounced. There is absolute dulness up to the third interspace on the left side of the sternum, with neither pericarditis nor valvular disease. In the absence of valvular disease we have additional proof that the disease is chronic interstitial nephritis.

It is said that this cardiac enlargement in chronic Bright's disease may be due to one of several causes. Some maintain that it is due to the increased resistance which the heart has to encounter in driving the blood through the contracted kidney. But when we consider the smallness of the kidneys as compared with the whole area of the circulation, and how far they are from the seat of circulation, this does not seem reasonable. Further, ligation of the renal arteries is found to produce but temporary increased intra-vascular pressure. Again, cardiac hypertrophy associated with a hypertrophy of the middle or muscular coat of the arterial wall is said to be brought about by the increased effort on the part of the arterial walls to shut out from the portions of the body under their protection the blood which is poisoned by matters which the diseased kidneys fail to eliminate, and that as the nephritis increases and the amount of poison accumulates, the thickening increases. The heart tries to overcome this resistance against which the vessels react, and thus the two hypertrophies increase each other. The next theory is more recent and has been alluded to. It is that interstitial nephritis is not a disease of the kidneys, but of the whole vascular system, in which the kidneys bear merely their part of the general trouble. The advocates of this theory maintain that the blood-vessels are the seat of an inflammatory change, constituting an endarteritis which causes an exudation and later an atheroma of the blood-vessel walls; that this affects the kidney no more than the rest of the arterial system, of which the heart is also a part. This theory, while it explains the overgrowth of the inner coat of the blood-vessels, does not explain the muscular hypertrophy. To meet this, it is claimed that the thickening of the vessel walls is not due to the thickening of the middle, or muscular, coat, but rather to a thickening of the inner coat, which in reality makes them weaker than before; so that in this form of Bright's disease we are apt to meet with hemorrhages from the rectum, nose and other mucous membranes, as well as with miliary aneurisms and attacks of apoplexy, which is undoubtedly a fact. But the fact also remains that there does constantly occur hypertrophy of the muscular coat, although there is also endarteritis.

The inflammation of the blood-vessel walls is easily explained by the irritating presence primarily of blood charged with alcohol, lead, the poison of syphilis, and even rich and irritating foods highly charged with nitrogen, as well as secondarily by poisonous and effete materials, that the kidney ought to remove. It is consequently a part of the morbid anatomy of gout, as is also interstitial nephritis. It may occur also from lead poisoning.

## COMMUNICATIONS.

### COMPOUND FRACTURES AND THEIR TREATMENT.[1]

BY W. L. BUECHNER, M. D.,

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A few years ago compound fractures of the long bones were considered very serious injuries, the mortality in such cases often being alarming. Aseptic surgery has brought a change. Gangrene, traumatic erysipelas, pyemia, and even secondary hemorrhage formerly following such injuries so frequently, have almost become things of the past.

To Professor Richard von Volkmann belongs the credit of having brought the treatment of compound fractures nearly to perfection. In 1886, while visiting his clinic, I found his statistics showing 300

[1] Read before National Association of Railway Surgeons, May, 1890.

cases of such injuries without a single death from sepsis. To obtain such favorable results it is absolutely necessary to pay the closest attention to the first dressing, for on it depends the fate of the limb and probably the life of the patient. The injured limb should first be washed with soap and water and cleanly shaved, and then washed with a solution of carbolic acid (five per cent.) or bichloride of mercury (1-1,000). If necessary the wound should then be sufficiently dilated with the knife, to admit easily the index finger, which being introduced, the wound is washed out under a stream of carbolized water, and every recess which may have formed in the soft parts cleansed; long pockets should be incised at the lowest point to admit of free drainage; small incisions should be made to wash everything out thoroughly, and no blood coagulum should be permitted to remain; every loose piece of bone should be carefully removed, only those adherent to periosteum should be left, and retained in their position, if necessary, by wire screws or nails. Should the end of a fragment be very sharp so as to interfere with the reduction of the fracture, or should it show any disposition to perforate any muscular structures, it should at once be removed with the bone forceps, or saw; for this purpose it can easily be brought out of the wound by gentle bending of the limb. Should any pieces of bone lie under the fragments, or should any pockets in the torn muscular structures be found, the fragments may be turned out of the wound, and everything cleaned out with the utmost precision. Muscular fibres, so frequently found between the fragments, should be carefully removed, as they retard consolidation and are often the cause of false joints. Pieces of integument and portions of muscular structures which are crushed beyond a possibility of saving, should be removed with the scissors; the whole wound is then to be washed out again with a stream of carbolized water, then the drainage-tubes are introduced and it is better to use numerous short ones than only a few long ones. Where any incisions are made through torn loose integument, the drainage-tubes should only be ¼-½ inch long. Every incision is then closely stitched up to the drainage-tube. In the same way the whole wound should be closed, if possible; the drainage-tubes in the main wound should go down to the bone, but never between the fragments. All drains are cut off at a level with the surface, and to prevent their slipping back are held by silk being attached to them, or by simply transfixing the end of the tube with a pin. The limb is then held by some assistants in the lowest position, to have the needed extension and counter-extension. The wound is then thoroughly irrigated with a solution of bichloride of mercury (1-1,000) then with flatly laid-on hands all superfluous blood is squeezed out of the wound, and only enough of it left to fill the crevices between the fragments and the spaces between torn soft parts, and the rest of the wound that cannot be closed by sutures. These layers of blood should never be disturbed. They close all the parts together and in course of time become organized. No fistulous openings should ever be found afterwards going down to the fragments and even considerable pressure should not bring any secretions from the deeper parts of the wound. The wound and its surroundings are then covered with many layers of iodoform or sublimated gauze, either being very serviceable in absorbing all secretions. The gauze is then covered with light cushions filled with moss or oakum and the whole dressing held in position by roller bandages made of crinoline, dipped in a 3 per cent. solution of carbolic acid. The bandages are applied so that at least three thicknesses will cover the dressing. In all severe cases with numerous drainage-tubes and incisions the dressing should be changed every four or five days to see if everything is in position and doing well. The second dressing is applied the same way as the first. Afterwards the dressings are changed only every eight days. As soon as the wound is not secreting any more, the drainage-tubes are removed; this can frequently be done at the second dressing. By this time the wound, where it could not be entirely closed by stitches, should be found covered with a darkened, moist but solid coagulum, or a peculiar glassy exudation. Every examination of the wound by probe or finger, all washing out or other interference, should be strictly avoided. The fractured bones should never be exposed again after the first dressing and nowhere is meddlesome surgery more out of place than here. Should we find, after the removal of the first dressing, that the fracture is not covered with fine blood coagula, it would be well to scarify the edges of the wound, to furnish in that way the necessary cover. The dressing should be applied rather tightly to bring all torn muscular

fibres into close contact with one another. The blood will close them together and they will heal by first intention. Should, at the time of dressing, some secretion appear on the surface, it should be carefully wiped up with carbolized cotton. There should not be a drop of pus, the secretion simply consisting of a somewhat gelatinous serum. The dressing should be continued in the same manner till the wound is entirely healed.

It sometimes happens that small pieces of necrosed bone will be thrown off, but that will not cause any complications, as they are generally very superficial. Those lying deeper in the wound are frequently absorbed without any disturbance. Has any metallic substance been used to keep the fragments in their proper position, it may safely be left in the wound till the fragments are united, it will become loose and can be extracted without difficulty, although the wound closes frequently entirely over it, and a small incision may be necessary for its removal. To give the fractured limb the necessary support and steadiness, splints should be applied. Heavy tin is preferred by von Volkmann for that purpose, but other material or plaster of Paris may be used according to the preference of the attending surgeon. I use the tin splint for all fractures at first. In simple fractures a plaster dressing is applied about the eighth day; in compound fractures as soon as the flesh-wounds become small enough to be treated through the windows of a plaster dressing. The dressing should always immobolize the joints above and below the fracture; and then the patient should be compelled to put at least a part of his weight upon the limb, and the results will be more uniformly good in less time than when the patient is not allowed to bear any weight on the limb. I never had occasion to regret the above-described treatment, and a case, coming under my observation, seems to me to prove its correctness.

The patient, W. L., a brakeman, had sustained, in a collision, a simple fracture of the right leg, and a compound fracture of the left leg. The compound fracture was treated according to rules laid down in this paper, and the limb placed in a tin splint. In eleven days the wounds of the soft parts were completely healed and a plaster of Paris dressing applied. In eight weeks the dressing was removed. No callus had formed at the site of the fracture of the left leg (there was only a ligamentous union) and the fragments of the bone were movable. Another plaster dressing was applied and the patient ordered to walk around and bear some weight on the limb. He soon complained about some soreness at the site of the fracture, which gradually subsided, and when in six weeks the dressing was taken off, a good callus had formed, the bones were firmly united, and the man has two good legs to-day.

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## THE ELECTRICAL TREATMENT OF SALPINGITIS AND ALLIED CONDITIONS.

BY G. BETTON MASSEY, M. D.,

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Before offering what I have to say on the electrical treatment of salpingitis, there are certain preliminary statements, relative to this disease and its treatment, that are forced upon me by the extravagant position of certain members of the profession.

I wish first to affirm that there is no evidence that justifies the assumption that this condition is a dangerous one. In neither stage of its existence, from the catarrhal inflammation that has involved the mucous membrane only slightly, to the hypertrophied and distended tube filled with mucopurulent material, is there a menace to the life of the individual. The statement is made by those who resort freely to capital operations, that a woman with such an accumulation within her is in danger of rupture and death from peritonitis. In answer to this I will quote a few sentences from a recent lecture[1] by Dr. Morris Longstreth, one of the physicians to the Pennsylvania Hospital. "This specimen [a cystic tube] illustrates what I believe is the end to which all of these inflamed Fallopian tubes would come if they were let alone. The active inflammation closes the openings of the tube, and lymph and pus are thrown out into the tube and accumulate there. When the tube becomes full, the blood supply is interfered with from the pressure within the tube, the thick product undergoes a mucoid degeneration, and a large cystic tube is produced, larger than it was when the pus was in it. In tubes like these, which have become wholly cystic, and in those in which sup-

[1] MEDICAL AND SURGICAL REPORTER, May 3, 1890.

puration is still going on, microscopic examination reveals that they are not pus cavities, as is claimed by some gynecologists, but that they are lined with perfectly healthy mucous membrane, lined in many cases with columnar cells. Therefore this process is not a true suppuration. Many gynecologists remove these tubes, urging as their reason for so doing that there is great danger that the inflammation will spread from the tube and reach the peritoneum, and there light up an inflammation which will produce certain and speedy death. This would be true were the process in the tube a true suppuration; but it is not, and there is no such danger to be dreaded. The records of this hospital for twenty years past do not show any death from the bursting of these suppurating tubes, or from peritonitis arising from this condition."

Such is the statement of the pathologist of one of the most active hospitals in America. I am convinced that those who have formed a different opinion as to the danger of "pus tubes" have permitted themselves to mistake pelvic abscesses arising in the connective tissue for intra-tubal collections. The assumption now common that all pelvic abscesses are tubal in origin involves a complete disregard of the existence of lymphatic vessels and glands in the pelvis. I cannot believe that these absorbing and draining vessels fail in this region to perform the duties discharged by them in other parts of the body; and there can be no question that many abscesses arising in a poisoned and softened gland have been incorrectly attributed to the tubes. In a conversation recently, Dr. Formad, the well-known pathologist and coroner's physician, of Philadelphia, admitted to me that a considerable proportion of the cases of this nature seen by him *post-mortem*, showed signs of having originated outside the tubes. True abscesses of this nature are of course dangerous and necessitate surgical intervention. They have nothing in common with the distended tube, and it is my belief that they may be largely differentiated from them by attention to the temperature. Eliminating the cases of pelvic abscess, then, from those presenting distended Fallopian tubes, it will be seen that a condition is left in which it is safe for the physician to attempt to restore the functions of the part before consigning the patient to the dangers and uncertainties of an abdominal section and the limbo of a neutral sex for the remainder of her life.

The advocates of early operation, again, have placed themselves in an awkward position by dwelling also on the difficulties in the way of exact diagnosis. The two positions seem to me incompatible; but that the operative furore leads to such discoveries of diagnostic errors there can be no doubt. I have myself seen patients from whom ovaries had been removed for colitis, lateral spinal sclerosis, spinal meningitis, locomotor ataxia, gummata of the spinal canal, neuralgia, neurasthenia, Basedow's disease, and a host of other nervous affections; the condition of the patients subsequent to such unwarrantable mutilations being of course most deplorable.

If it is true that we cannot diagnosticate this disease with accuracy, we should, in justice to the patient, adopt a line of treatment suited to all the conditions that cannot be excluded; and while it has been my experience that electrical treatment is more effective in the inflammatory troubles than in the nervous affections mentioned, in none of them is it contra-indicated, and in many it may be either curative or beneficial.

In considering the methods by which a salpingitis may be cured we should examine somewhat into the nature of the process that results in a simple catarrh of patulous tubes, or in the muco-purulent collections that form when the tubal extremities are occluded. It may be taken for granted that no case of catarrhal salpingitis arises within the tubes *de novo*. All such inflammations ascend along the mucous tracts, and before the salpingitis we necessarily have an endometritis. Adopting the same order in our curative effort, we should first aim to subdue the active or latent endometrical inflammation, initiating thus a reparative process which will extend upwards of itself. This, at least, seems to be the explanation of some typical results that I have recently had, in which negative Galvanic applications to the uterine cavity were followed by discharges of pus from pus tubes and subsequent normal pregnancies.

To accomplish this result requires some circumspection, as it is well known that intra-uterine applications are apt to relight the slumbering fires of even sub-acute conditions, and it is my practice to temper such conditions first by negative vaginal applications, 25 to 60 milliampères, before employing the intra-uterine treatment. The intra-uterine dosage should begin with 10 milliampères, to be subsequently increased if necessary. If the salpingitis is of the kind that is more

properly called a salpingo-ovaritis, presenting great tenderness in the region of the appendages and an accentuation of the normal outlines of the pelvic contents, but without definite sign of uterine catarrh, the treatment should not be extended beyond the vaginal variety, and will almost invariably meet with the happiest results.

One case of success of this nature is worth many cases of success after ablation of the parts. For the details of two cases followed by normal pregnancies I refer to a paper in the *Annals of Gynecology*, February, 1890. Numerous other cases may be cited, as it is my experience that at least fifty per cent. of such tubes may be made patulous by producing resolution in the inflamed mucous membrane. Whether or not such a proportion will remain free from subsequent attacks, depends entirely upon the observance or neglect of hygienic regulations that are often difficult to enforce.

In cases in which caution is advisable in the intra-uterine applications I have found that less immediate irritation followed when the electrode was not passed quite to the fundus, being inserted but one and a half inches or two inches. Mild purgation, seclusion, and rest are important adjuncts to the treatment; and in no distinctly local disease are the approved methods of treating neurasthenia more applicable as a help.

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## DRUNKENNESS A SYMPTOM OF DISEASE: NOT A HABIT OR A DISEASE PER SE.

BY D. H. MOUNT, M. D.,
BAYHEAD, N. J.

Some observations as to the causes of intemperance have led me to believe that drunkenness is not a habit, but is caused by either of two things: a love of convivial habits and the companionship of those of like tastes, or some derangement of the system, most generally of the organs of digestion; and in the latter case is a symptom of a disease, which, like neuralgia, can often be cured if the disease which causes it can be reached.

Dr. J. C. Wilson makes the following four grand divisions of alcoholism:

1. Acute alcoholism.
2. Chronic alcoholism.
3. Hereditary alcoholism.
4. Dipsomania,

with numerous sub-divisions, but for practical purposes suppose we call them all by the broad, plain terms, drunkenness of the convivial man and of the chronic drunkard.

How often do we hear it said of a man, "He is a good workman, but he will occasionally have his sprees, which last for two or three days and then he will be all right again." Can there be any habit in this? A habit which is irresistible is something that is indulged in much more frequently and with much more regularity than the ambiguous word occasionally would express. Now it is a fact that, as the years roll on, these occasional sprees are more apt than not to become more and more frequent until at last it gets to become one continuous "occasionally."

Now, what is the reason for this occasional spree? Here is a man who is a good workman, a good salesman, or a good minister of the gospel, is it reasonable to think that this man deliberately and intentionally throws away his chances in life, is it reasonable to think that this man makes himself miserable from choice? Is it not more reasonable to think that there is some power over which he has no control which impels him to drink to intoxication day after day?

Old miners who are miles away from any place where intoxicants can be had, say that when they are feeling badly and can't eat, nothing does so much good as to go to the nearest town and "blow it out," that is, get very drunk for a day or two.

What is the explanation of this? Is it possible that in their case the liver has become sluggish and that the vomiting and purging which they bring on by their overdoses of alcohol really does give them the "cleaning out" which they speak of, and set things moving again until the next attack comes on? And would some remedy acting on the liver do the same work in a shorter time and quite as effectually as the spree?

But you will say, all these bad symptoms which the miner complains of are present in the confirmed drunkard, and so they are, but we all know that in taking any medicine, especially in chronic diseases, the poison line shifts and the dose has to be increased constantly until at last the remedy fails entirely and something new has to be tried.

Could not this, too, be true of the drunkard who, unconsciously, at first employed a

remedy for a disease which, in the course of time, has become less and less efficacious until at last it fails him entirely and he is not comfortable unless under the influence of alcohol and finally sinks into the so-called drunkard's grave?

If this is true, could not the disease which causes the drunkenness be reached by some remedy, and as the symptom neuralgia is often cured by the removal of a tumor or by attacking the disease which causes the neuralgia, so drunkenness be cured by attacking the disease which causes it?

That drunkenness is hereditary in some families is, I think, generally admitted. Some young men seem to take to intoxicants from the first as their fathers did before them, but so do some young men seem to develop consumption as their fathers did before them. Some families seem to have in them the curse of one kind of hereditary disease and some another kind.

At times a whole generation may escape the dread disease, only to have it break out in the one following, and as families in which consumption is hereditary should use great care to prevent the disease from appearing, just so families where drunkenness is hereditary should teach their children, from the first, the danger to which they are liable. The great trouble is that as many people have searched for a cure for neuralgia and not the disease which caused the neuralgia, so doctors have sought a remedy for drunkenness without taking into account the disease which causes it.

In considering the subject, the convivial drinker must be left out of the question entirely. He drinks because he thinks it a great pleasure; he is perfectly healthy and would probably not drink anything could he find no companions to drink and talk with.

To be sure, his organs of digestion may give out at any time as any one else's might, and he, too, may drift into the remedy rather unconsciously and in the end drink for a far different reason from what he did in the first place; and this, too, I consider a good argument that drunkenness is a symptom of disease, because the convivial man hates the sight of an habitual drunkard.

The two men are as different as day is from night and there can be little similarity between them. The drunkard is seldom or never from under the influence of alcohol, whilst the convivial man goes off for a day's fishing or to the races and has a "good time," gets "drunk as a lord" because somebody else got drunk, talks it all over the next morning as to who was the drunkest the night before, and then goes home and about his business until he meets with another crowd bent on having "a good time."

The drunkard is far different. He drinks because it makes him feel better. He is not apt to be jolly; on the contrary, he is apt to be ugly towards those around him, or he is quarrelsome or may be stupid and say nothing. The drunkard is generally miserable, so miserable that he often blows his brains out or in some other way makes way with himself, because being sane he knows his condition, but after frequent trials knows that he cannot stop drinking. This is the man of whom I would speak; this is the man whom I claim needs the care of the doctor.

The drunkard has always been and is now shunned by the general practitioner, who tells him, when he is consulted, to "stop drinking," and then shoves him aside because he looks on him as loathsome. Just as well might the doctor treat the syphilitic patient or the small-pox patient in the same manner, were it not that small-pox is a recognized disease which is understood and has been thoroughly studied, whilst alcoholism has been comparatively neglected.

Another and by no means a small cause for intemperance is the quality of the liquor sold. From the debauch on one grade of liquor a man may awaken the next morning feeling in a comparatively good condition, whilst a spree on a poorer article makes him feel wretched and leads him to drink more of the same stuff in his efforts to "brace up" and make himself comfortable. Drs. Dujardin-Beaumetz and Andigé, in their report to the Institute of their researches on chronic alcoholism during 1879–1883, say that among the pigs with which they experimented the action of the impure alcohol was much more rapid and deleterious than from rectified alcohol. For this cause of intemperance the Prohibitionists are undoubtedly responsible in a very great measure, because he who desires a drink of alcohol will get it in one way or another, law or no law, and where the risk of selling is the greatest, there the newest and poorest liquor is invariably sold, hence the effect produced is much worse than in places where competition compels the seller to supply a comparatively good article.

If half the energy displayed by these exceedingly well-meaning people, whom I greatly respect, in trying to do a thing which they have not been able to accomplish after years of trial, and certainly in Maine have made matters far worse for the reason that I have mentioned—if even a small part of their energy could be devoted to the proper government of the traffic many of the saloons might be abolished and a better article sold to the consumer. As it is now too much encouragement is given to men to go into the traffic.

The seller can buy a gallon of whiskey for, say, 85 cents; this gallon, I am told, will average about 144 drinks, to say nothing of the water which he may add to the original gallon. One hundred and forty-four drinks at 10 cents a drink is equal to $14.40, a profit of $13.55, therefore if the seller has only fifteen customers a day he will be making as much as if he worked by the day's work, provided the workingman can get work every day.

This the Prohibitionist could remedy by making the business less profitable, which could be done as follows:

Let there be inspectors of all places where liquors are sold, appointed after the manner of revenue inspectors, whose duties it shall be to procure samples of the liquors sold in the different places and see if they are up to a certain standard, which might be fixed; the liquor to be sold by measure at a price fixed by the government. By regulating the quality, the quantity and the price, the business of selling would then become one in which there would be no more profit than any other retail business; and, as the occupation is by no means a pleasant one, fewer men would be induced to enter in it. But the chief benefit would be in the effect on the consumer which, as previously claimed, would be far different than where the new article is supplied.

M. Lancereaux, before the Académie de Medicine, November, 1885, after showing that alcoholics come chiefly from districts where wine is not produced, proposed the national adoption of the following measures:

1. Absolute liberty in the sale of cider, beer and wine, on condition that they are of good quality and unadulterated.

2. Government supervision of the manufacture of spirits of all kinds and the granting of prizes for methods of diminishing their ill effects.

3. The imposition of the highest practicable tax upon spirituous drinks and an insistance upon both the good moral character, and a severe license in the case of liquor dealers.

4. The punishment of those found in the state of intoxication and the establishment of refuges for those who cannot abstain from the abuse of strong liquors.

In this country high license is being tried, but this still leaves the consumer unprotected and, because of the temptation of the seller to keep an inferior grade of liquor to counterbalance the high rate of the license, is rather conducive to intemperance than a preventive.

Of the reformed drunkard, so-called, I think it may safely be said there are none where the predisposing cause still exists. One of the worst cases of alcoholism I have ever been called on to treat, was in a man who had abstained from intoxicants for four years. In his case the cause, a bad, irritable stomach and a sluggish liver, had returned and brought with it the old irresistible craving for liquor. The reformed drunkard may point to his improved condition, etc., but if you look into the matter I think you will find that the reform began at a time when the conditions were changed. Cures of drunkenness have been reported, many of them, among which the administration of strychnine plays an important part, but I do not think that any specific will ever be found, rather would I believe that more attention will be given in the future as to what makes a man drink when he knows that it is for his best interests not to drink.

The disease theory of drunkenness dates back from the second century, when the Roman Ulpian urged the treatment of inebriates as sick and diseased. In 1747 Condillac, of France, urged the provision of hospitals. Since then many other eminent men, among them Drs. Rush, of Philadelphia, and Esquirol, of France, have urged the same thing.

The mention of the theory, however, has always roused such intense feeling that comparatively little has ever been done.

The following statistics by Baer, of Berlin, obtained from observations in England and Germany, comparing the years of life to be expected by persons of various ages, who were not handlers of alcohol, with the years of life remaining to those who used alcohol constantly, may be of interest.

Non-handlers of alcohol aged

| | | | |
|---|---|---|---|
| From 25 | years had before them | 32.08 | years |
| " 35 | " " | 25.92 | " |
| " 45 | " " | 19.92 | " |
| " 55 | " " | 14.45 | " |
| " 65 | " " | 9.72 | " |

Those who constantly had to do with alcohol had a future of

| | | | |
|---|---|---|---|
| From 25 | years of age | 26.23 | years |
| " 35 | " | 20.01 | " |
| " 45 | " | 15.19 | " |
| " 55 | " | 11.16 | " |
| " 65 | " | 8.04 | " |

These statistics might be somewhat changed were small-pox or any other disease neglected or looked on as alcoholism is by most people.

In conclusion, let me again call the reader's attention to the fact that it is not for the benefit of the convivial drunkard that this is written, but for the poor, miserable man who sees his business drifting from him, day by day, without his being able to stem the current and who would help himself if he could, but has not the ability to do so. To this man I think the doctor can do good.

## FOREIGN CORRESPONDENCE.

### LONDON LETTER.

*Effect of Hospitals on Standard of Health.—Curious Delusion.—Vaccinating by Machinery.—Effect of Summer on Medical Work.—Tait's Operation for Lacerated Perineum.—Inflammable Gas in the Stomach.*

The hospital controversy brings forward prominently the extensive provision that modern society makes for the fostering of its incapables. There can be no doubt that the health standard of the race is materially lowered by the system of dwelling in towns. The smoke-laden air, unhealthy occupations and insanitary dwellings combine with dissipation and over-pressure to sap the strength of the population. The lives of those who are thus crippled in the struggle for existence, however, are artificially preserved by a far-reaching organization that sweeps the disabled of all sorts and conditions into its net. Skilful medical treatment, on a large and elaborate scale, is provided for the cripples, the imbeciles, the insane and for all sufferers from sickness or accident. That this excessive aid has an ultimate ill-effect in levelling down the national standard of health is more than probable, for the patched-up folks are free to marry and add their unhealthy offspring to the sum total. The remedy to the situation is tolerably clear to the political economist, but when an ordinary citizen comes to inquire into the question it is found to be hedged in with apparently insurmountable difficulties. Sentiments and prejudices, the outcome of long ages of social evolution, are, fortunately for ourselves, slow in yielding their ground. Most thinking men who have ventured to give utterance to their ideas seem to agree that eventually the question of limitation of marriages—at any rate, amongst unhealthy people—will have to be dealt with by the State. The mere increase in numbers will one day render some step in this direction an absolute necessity. Meanwhile the problem is not only difficult but is of such a delicate nature that few public men care to approach it. One point can hardly fail to appeal to the common sense of all classes of the community, and that is the extreme inadvisibility of allowing lunatics to leave their asylums and marry during their remissions, thus keeping up constant additions to a most undesirable breed.

A curious case of mental delusion lately came under the present writer's notice. The patient, a middle-aged man who had formerly been in good circumstances, was visited by an out-door medical officer of the Poor Law relief. When asked what he was complaining of, the patient replied, "Weeds, sir, weeds in the bladder," and pointed out three bottles on the bed-room mantelpiece. On inspection these were found to contain chopped water-cress, hair, feathers and other foreign material. Falling in with the humor of the position, the doctor mildly remarked that the poor man appeared to have not only a water-cress bed but several fowls and a hair mattress concealed somewhere within his internal economy. At this seeming slur upon her husband's veracity, the wife left the room in high dudgeon, for she, at any rate, was a firm believer in the extraordinary symptoms. The doctor then expressed a wish to see some of the offending material actually voided. The patient at once assented, but first crossed the room to get a large sponge of warm water, saying that was a necessary accompaniment of the proceeding. That was of course sufficient

proof of the malingering and the man was sent on to the hospital, whither he took several specimen bottles. He was kept in bed and watched for several days, when his urine, as might be expected, was found clear. Nothing, however, could shake his faith in the theory of the existence of the vesical weeds, and he was discharged, as his clinical condition hardly warranted further occupation of valuable bed-space.

The ways and means of modern surgery have been wonderfully extended of late. A good surgeon cannot have too wide an acquaintance with the physical qualities of the materials that surround him. Nor can he fail to benefit from a knowledge of advances in mechanical contrivances. A short while ago your correspondent saw an ingenious little instrument for vaccination introduced by Mr. Jordan Lloyd, of Birmingham, one of the vice-presidents of the British Medical Association. The instrument is simplicity itself, consisting, as it does, of nothing more than an American chuck-drill, costing a few pence, and fitted with a common sewing needle. When the operation is needed a drop of vaccine matter is blown on to the arm, a few scratches made and *hey presto!* the thing is over before the child has made up its mind to cry. One great point is the extreme ease with which the needle can be cleansed or renewed. Speaking broadly, simplicity is desirable in all things surgical. Many a surgeon would find it worth his while to follow Mr. Lloyd in availing himself of transatlantic ingenuity to add to his manipulative resources.

The summer months are somewhat of a dull time for the medical world, that is, from a scientific point of view, however busy it may be over professional work. The medical and the clinical societies have closed for the time, and the Royal Medical and Chirurgical will shortly follow suit. The same applies to the various provincial associations, which have for the most part closed their doors until next winter. Meanwhile, there is a surcease in the flow of articles that have for months past been flooding the journals. There is every reason to believe, however, that the accummulation is still going on, and that the accustomed deluge will break forth at the British Medical Association in August. It is difficult to imagine what would happen were all the pent-up literary energies of our learned profession not supplied with some such safety valve.

Surgeons all over the country are adopting Lawson Tait's operation for ruptured perineum. The results are excellent. So far from there being any loss of substance the patient is provided with a good substantial perineum and in favorable cases with a vaginal orifice of small size. The operation can be done rapidly, and its main points may be briefly described as follows. The first step is to run a scissors transversely along between the rectum and perineum, splitting what is left of the septum. At each end of this cross-incision two others are carried backwards and two more forwards, the latter being close to the margin of the ruptured surfaces. The incisions might be shown in diagram by the capital letter "H," with two short legs on the anus side of the cross bar. At this stage the wound gapes and a raw surface is left which has somewhat the shape of a skate's egg. Silkworm-gut stitches are now passed deeply in such a manner that they pierce nothing but raw surfaces. This done the two opposing halves of the wound are brought together. Superficial skin stitches complete the operation. In cases where the original deficiency was associated with prolapse of the uterus the new artificial perineum acts as a kind of natural pessary. Mr. Tait claims that his plastic perineum will stand the strain of further labors. That is undoubtedly true in some instances, but in one case at least known to the writer the new organ gave way at the next confinement.

One of those strange cases where inflammable gas is given off from the stomach has just been reported from Manchester. The patient was an operative suffering from chronic gastric trouble, and in the first place set fire to an eructation when striking a match to see the time in the early morning. The combustion seems to be due to the presence of hydrogen and of marsh gas, as the product of the butyric fermentation. An organic lesion was present in this case in the shape of stenosis of the pylorus. D. W.

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TYPHOID FEVER.—A. Wiltschour, of St. Petersburg, examined, in 28 cases, the stools of typhoid patients. He never found the specific bacilli earlier than the tenth day, after which date it was almost constantly present in the proportion of 1 to 25 or 30 of the other bacteria. In 35 cases where the blood was examined microscopically and by cultivation methods the characteristic bacillus was found once on the eighth day.

## PERISCOPE.

### The Hydrophobia Epidemic in New York.

An editorial in the *N. Y. Medical Record*, July 5, 1890, says:

One needs to be but a very casual and careless reader of the daily papers to have had impressed upon his mind the fact that reports of cases of hydrophobia in man and beast are becoming alarmingly frequent. Dogs, horses, pigs, cats, men, women and children, all over the country, are falling victims to the dread disease—if the newspapers are to be credited. Rabies has always existed in the world; indeed, one of the earliest terrors that appeals to the vivid imagination of the young child is that inspired by nursery tales of mad dogs, and many a timid girl, whose fears have been excited by these wicked stories, has been thrown into convulsions at the sight of a playful dog making friendly advances towards her. But the season for the nursery form of the disease, if we may so designate it, was always summer—the "dog days" being very appropriately selected as the time best fitted for the production of the malady, and the winter and spring were periods of safety. The present epidemic, however, has had no regard for tradition, but began early in the spring, or rather, late in the winter, and has steadily increased, regardless of meteorological conditions, since the establishment of the Pasteur institute. It is a curious fact that, in France and elsewhere, the prevalence of rabies has seemed to be closely dependent upon the rise of Pasteur institutes, and the more the institutes flourish the more numerous become the cases of hydrophobia among the community at large. Leaving aside the question of the existence of such a disease as hydrophobia, and whether, if it do exist, it may be prevented by Pasteur's method; or even admitting freely both these as actual and undisputed facts, it may well be asked how much the community gains by the creation in it of an institution for the treatment by preventive inoculations of rabies. Is the sum of human misery thereby diminished or is it increased? Of course, the widest publicity is essential to the success of such an undertaking. People cannot avail themselves of a good thing unless they know of its existence, and they can never know of it so quickly as when they are informed through the medium of the daily press. Consequently, hardly a day passes that the papers do not contain accounts of alleged mad dogs, and of the setting out of their victims on a pilgrimage to the branch Mecca of Pasteurism in New York City. What is the effect of all this publicity? Can any one doubt that it is to create needless alarm in many minds? Admitting the existence of hydrophobia as a distinct and well-defined disease, it is certainly one of exceeding rarity, and one may pass through a long professional life without seeing a single case in which the symptoms would suggest rabies. Yet, within the past six months we have heard of nothing so frequently as of hydrophobia. If our country were as thickly populated with abandoned curs as is the city of Constantinople itself (where, by the way, hydrophobia is said not to be recognized), we could not expect to have more cases of the disease than we are told that we have now. It cannot be doubted that many, if not all, of these cases are instances simply of fright, and that of those treated by preventive inoculations, so-called, not one in ten, at a very high estimate, is in the slightest danger of acquiring hydrophobia. The rest, and thousands of other people throughout the country, are simply frightened nearly to death. We have nothing against the Pasteur institute in this city, nor against the gentleman who has charge of it, and we believe that he is inspired with the highest motives and with a desire to popularize a method which he thinks will be of the greatest benefit to humanity; we will not argue as to the method itself, whether it accomplishes what is claimed for it or not; but we are firmly convinced that the establishment of such an institute in this country, with the popular agitation on the subject of hydrophobia to which it has given rise, is unfortunate, and has already been productive of an incalculable amount of mental anguish in those who may have been bitten by dogs, but who would never have given their simple wounds a second thought were it not for this newspaper notoriety.

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### Statistics of Cures by Hypnotism.

The methods and purposes of the clinic for the treatment of diseases by hypnotism, founded at Amsterdam by Drs. van Reuterghem and van Eeden are well known. On the occasion of completing the first two years of their experience, they have put

together an account of the kind and number of diseases treated, and the amount of success achieved; and these statistics, being comparatively extensive and carefully collected, have good claims to general consideration. There were treated, in all, 414 patients (219 men and 195 women). Of these, only 15 (less than 4 per cent.) could not be hypnotized; 217 (53 per cent.) entered a light stage of sleep; 135 (32 per cent.) entered a deeper stage; and 47 (11 per cent.) entered the somnambulic stage, characteristic of the best hypnotic subjects. The ages of the patients were distributed as follows: from 1 to 10 years, 9; from 11 to 20 years, 46; from 21 to 40 years, 203; from 41 to 60 years, 131; from 61 to 80 years, 25. There were 361 of the 414 afflicted with various kinds of nervous troubles, 168 were classed as general neuropathic disorders, 68 as neuralgias and pains, 60 as mental diseases, 40 as hysterical affections and 29 as organic affections. In general, the effects of the treatment are indicated by the following figures; no effect in 71 cases (20 per cent.), a slight or passing improvement in 92 cases (26 per cent.), a distinct and permanent improvement in 98 cases (27 per cent.) and a cure in 100 cases (28 per cent). The disproportion in the number of nervous and non-nervous cases makes a fair comparison of the results in the two classes impossible. Among the nervous diseases, those classed as neuropathic show a very favorable result, 33 per cent. being cured, and 26 per cent. permanently benefited. Hysterical and neuralgic affections show nearly as high a percentage, though the absolute numbers are here much smaller. Diseases classed as organic naturally show the very minimum of success in treatment. We have thus no announcement of hypnotism as a panacea curing all diseases, but a fair proportion of success and failure distributed among various disorders in a way that accords with our knowledge of the nature of such diseases. It is only by such impartial and scientifically collected results that the movement can make progress.—*Science*, Feb. 28, 1890.

## Milk Statistics.

The *American Analyst*, May 29, 1890, says, on the authority of the *R. I. Monthly Bulletin*, that there are $2,000,500,000 invested in the dairy business in this country. That amount is almost double the money invested in banking and commercial industries. It is estimated that it requires 15,000,000 cows to supply the demand for milk and its products in the United States. To feed these cows 60,000,000 acres of land are under cultivation. The agricultural and dairy machinery and implements are worth $200,000,000. The men employed in the business number 750,000, and the horses over 1,000,000. There are over 12,000,000 of horses, all told. The cows and horses consume annually 30,000,000 tons of hay and nearly 90,000,000 bushels of corn meal, about the same amount of oatmeal, 275,000,000 bushels of oats, 2,000,000 bushels of bran, and 30,000,000 bushels of corn, to say nothing of the brewery grains, sprouts and other questionable feed of various kinds that are used to a great extent. It costs $450,000,000 to feed these cows and horses. The average price paid to the laborer necessary in the dairy business is probably $20 per month, amounting to $180,000,000 a year. The average cow yields about 450 gallons of milk a year, which gives a total product of 6,750,000,000. Twelve cents a gallon is a fair price to estimate the value of the milk at a total return to the dairy farmers of $810,000,000, if they sold all their milk as milk. But 50 per cent. of the milk is made into cheese and butter. It takes 21 pounds of milk to make one pound of butter, and about 10 pounds to make one pound of cheese. There is the same amount of nutrition albumenoids in 8½ pounds of milk that there is in one pound of beef. A fat steer furnishes 50 per cent. of boneless beef, but it would require 24,000,000 steers, weighing 1,500 pounds each, to produce the same amount of nutrition as the annual milk product does.

## Effect of Ventilation on Micro-Organisms.

Dr. Richard Stern (*Zeitschrift für Hygiene*) has made experiments on this subject in a room in which he could have perfectly quiet air, or a more or less complete ventilation. The openings in the walls of the room were so arranged that he could admit the air from without, either at the upper part near the ceiling and convey it off near the floor on the opposite side of the room (winter ventilation), or the air could be admitted near the floor and conducted out at the opposite side of the room near the ceiling (summer ventilation). The rapidity

the ventilation was also under complete control. The air of the room was intentionally loaded with micro-organisms. Pure cultures were mixed with the dust collected from school-rooms and factories. This was then dried and pulverized and blown about the room. The air was then examined for the number of micro-organisms, by Petri's method at various times. The conclusions arrived at are: (1) That the micro-organisms rapidly sink to the floor in quiet air. The finer the dust upon which the micro-organisms rest the slower the gravitation. (2) The usual ventilation, effecting a renewal of air from one to three times an hour, has no effect upon the removal of micro-organisms with summer ventilation, and only to a very limited extent with winter ventilation. (3) Ventilation, effecting a more rapid renewal of air (six or seven times to the hour), does effect the removal of micro-organisms, but is scarcely to be attained without a sensible draught. (4) A rapid and complete removal of the micro-organisms from the air is only attainable with a strong draught. (5) Micro-organisms are not blown off from the floor, walls, furniture, clothing, etc., even with the stronger draughts. (6) The evolution of steam in a room is not capable of rapidly and completely precipitating the micro-organisms, although it hastens this process to a not very appreciable extent.—*Druggists' Circular*, May, 1890.

## Antisepsis Among the Ancient Greeks.

Professor Andreas Anagnostakis, of Athens, gives in the *Deutsche Medicinische Wochenschrift*, some interesting facts in reference to the employment of antiseptic measures among the ancient Greeks. Hippocrates and Galen were aware that an unclean condition of wounds retarded healing. They were also well acquainted with the fact that by thorough hemostasis, suture and the employment of antiseptic measures, infection of wounds might be prevented. Hippocrates warned his disciples against the use of moist dressings, on account of the danger of suppuration, and forbade the employment of drugs before the wound was dry. Above all, says Galen, avoid dirt, as it prevents healing. The ancient Greeks boiled their water before applying it to wounds. Sponges were avoided, and charpie recommended in their stead, which was to be destroyed after use. One of the principal antiseptic substances then in use was wine, which was usually heated before using, and with which, according to Hippocrates, all wounds were to be washed. Dressings dipped in wine were also applied to the wound. Salt was in very general use, either in solution or in the form of sea-water. The solutions were rendered aseptic by boiling. Sulphate of copper was relied upon as an antiseptic for foul wounds, and was also put into use as a hæmostatic. Tar was highly praised for its antiseptic virtues and was either applied in the form of a dressing or directly poured upon the wound. Besides these, many aromatics and bitters were in daily usage, among which were thyme, rosin, asphaltum, etc., used as dressings, or in the form of plasters. Galen was acquainted with catgut and advised the use of non-putrefying substances for sutures. Prof. Anagnostakis declares that all this was not empiricism, but an antiseptic method founded upon some knowledge of the principles governing the healing of wounds.—*Druggists' Circular*, June, 1890.

## Treatment of the Eczema of Dentition.

In the *Journal de Médecine*, July 28, 1889, Besnier says that he thinks the eczema of dentition is a reflex eczema. There are three indications for its treatment. First, to allay the irritation of the gums; second, to overcome the insomnia; third, to cure the local condition. For the first indication it is advised to rub the gums frequently with the finger, moistened with the following solution:

℞ Cocaini hydrochlor. . . . . gr. i
Potass. brom. . . . . gr. x
Aquæ dest.
Glycerini . . . . . aa ʃʒ iiiss

For the second indication the following mixture may be given in doses of a teaspoonful or a dessertspoonful:

℞ Sodii brom. . . . . gr. ivss–viiss
Syr. auran. flor. . . . . ʃʒ ii

For the local condition, applications of the following ointment should be made:

℞ Zinci oxidi . . . . . ʒ ii
Vaselini . . . . . ʒ vi

The affected parts should also be covered with a thin rubber or muslin mask.

### Helianthus in Intermittent Fever.

The *N. Y. Medical Record*, July 5, 1890, says on the authority of the *Rivista Clinica e Terapeutica*, May, 1890, that Dr. Maminoff has obtained excellent results in certain cases of malaria in children from the use of helianthus annuus, a remedy recently proposed by Rosatchkoff, of St. Petersburg. The tincture of helianthus, one part in five, prepared from the flowers and bark of the plant, is a yellowish-green liquid, almost tasteless, and without odor. It may be administered to children in doses of from ten to twenty-five drops three or four times a day. The first case in which Maminoff made use of this tincture was in his own child, three years of age, who had contracted a quotidian fever that resisted the action of quinine and of Fowler's solution in pretty large doses. He then had recourse to the tincture of helianthus, and on the second day the access of fever was very sensibly reduced, while from the fourth day on it had disappeared entirely The drug was continued for a week, or until the tumefaction and tenderness of the spleen had disappeared. A fresh paroxysm of fever appeared at the expiration of a month, but yielded at once to the helianthus and never again returned. This success led the author to make a number of experiments with the remedy in his clinic of children's diseases, prescribing it in place of quinine for malarial fevers. In every instance the results of this mode of treatment were excellent, old cases especially yielding promptly in three or four days.

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### A Case of Dextro-cardia.

Niesel, assistant at the clinic of Mosler, at Greifswald, reports in the *Deutsche medicin. Wochenschr.*, June 5, 1890, the case of a man, 20 years old, in whom existed the physical signs of displacement of the heart to the right side of the chest, without inverse transposition of the vessels. The patient has always been healthy, had never complained of palpitation and only recently had observed shortness of breath on great exertion. He came to the hospital on account of pain in the left side, following a fall. There was right-sided pleurisy, with effusion. Percussion over the normal area of cardiac dulness was resonant, over the corresponding area upon the right side, dull. Pulsation was slight to palpation, and the cardiac impulse was faintly visible in the fourth intercostal space, close to the right margin of the sternum. The heart sounds were loudest at the lower extremity of the sternum and at the right border of the heart. The first sound was stronger at the former situation than at the latter. In the left second intercostal space, close to the sternum and over the left half of the sternum, the second sound was stronger than in the corresponding situations upon the right.

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### Lysol.

Gerlach, before the Society of Physicians of Vienna, discussed lysol, a new antiseptic, derived from coal tar, yet free from carbolic acid. Its activity depends upon the cresoles contained. Its advantages over other antiseptics, especially carbolic acid and creolin, are said to be: 1, that its bactericidal activity exceeds that of creolin and of carbolic acid, as well in its influence upon vegetative as upon permanent forms of organisms; 2, it is less toxic than creolin and carbolic acid; 3, it is not a secret preparation and its composition is constant; 4, it is cheap; it is soluble in water; in the treatment of wounds, etc., solutions of ½ to 1 per cent. are used.—*Deutsche medicin. Wochenschrift*, June 5, 1890.

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### Nona.

James F. Hartigan, U. S. Consul at Trieste, under date of May 17, 1890, makes the following statement relative to the reported disease "la nona":

"Some credence having been given to the rumors about the so-called disease 'la nona,' I have taken occasion to inquire into the subject. The name is derived from the Italian, and is supposed to mean grandmother; but what connection it has with this much-respected person is not explained, except that she is given to dozing.

"So widely circulated were these reports, and they attracted so much attention on account of the alleged peculiar symptoms, that the Austrian Government issued a circular inviting inquiries as to its existence. The result has been entirely negative; not one authenticated case was discovered. Neither can a case be substantiated in Italy, where it is said to have originated, by competent medical authority. Dr. Constantine, the sanitary physician of this port, during a re-

cent visit to Rome, could learn nothing to verify it.

"These extravagant rumors doubtless had their origin in a few stray cases of uræmic coma that were not understood, or some like condition."

This statement, from the *Abstract of Sanitary Reports*, U. S. M. H. S., may be taken into consideration with those already published in the REPORTER and other medical journals in regard to the curious phenomenon.

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### Displacement of the Testicle.

At the clinical meeting of the Hunterian Society of London, held April 9, and reported in the *Lancet*, April 26, 1890, Dr. W. Fowler showed an example of displaced testicle in a patient seventeen years old. Over the left saphena opening was a superficial fluctuating tumor about the size of a split Tangerine orange, at the lower part of which the testis and cord could be felt. Above the tumor was an ill-defined fulness reaching up to Poupart's ligament. Here alone there was very slight impulse on coughing, but not that characteristic of bowel. When lying down a certain amount of fluid could be displaced from the tumor into the fulness above it, as though the processus vaginalis were not obliterated. The displaced testicle was small, tender and possessed testicular sensation. The lump had been noticed about ten years, lessening in size on lying down. The only inconvenience had been some aching in the part, especially after exertion. The patient wore a truss for ten years in the belief it was a hernia. He is in apparently good health except for chronic constipation. In former years he used athletics. Excision was recommended on account of the dangers: First, that hernia might follow; second, that the gland might take on sarcomatous growth.

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### Antipyrin and Antifebrin in Polyuria.

In the *Meditzinskoïe Obozrenië*, No. 5, 1890, p. 487, Dr. I. I. Maslovsky, of Bürnak, draws attention to antipyrin and antefebrin as remedies for diabetes insipidus and adduces an interesting illustrative case referring to a sickly and highly nervous peasant-lad, sixteen years old, with polyuria of a nervous origin and of six years' standing, in which the use of these drugs was followed by a striking and apparently permanent decrease of both thirst and amount of urine. Antipyrin was administered at first in eight-grain doses four times daily; later twelve grains five times a day; then finally twenty-four and twenty-six grains four times daily, the whole course lasting thirteen days. The daily quantity of urine fell from 11.700 cubic centimeters to 6.100; that of water ingested from 10.600 c. c. to 6.200. After an interval of three days, antifebrin was resorted to in from six to eight-grain doses four times daily, for eight days. The daily quantity of urine decreased from 6.300 c. c. to 4.100; that of water ingested from 7.450 to 4.590. No unpleasant accessory effects were ever noticed from either of the remedies.

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### Suicide by Means of a Pin.

At a recent meeting of the Société de Chirurgie, of Paris, reported in part in the *Medical Press and Circular*, April 30, 1890, M. Magnan related the case of a young woman who had fallen into melancholia, and expressed frequently the determination of destroying herself. In spite of close observation she succeeded in plunging an ordinary-sized pin under the left breast. The instrument passed through the sixth intercostal space, the pericardium, and lacerated the myocardium. Death supervened from syncope, the heart stopping from a quantity of blood filling the lower part of the pericardium, although no important vessel was wounded.

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### Raising the Grade.

In a recent issue of the *Popular Science News*, it is stated that Dr. Hartwig, of Buffalo, N. Y., proposes a plan for raising the standard of the medical profession in this country, which he considers more practicable than any yet suggested. He would have a separate class of practitioners established by the State to be called "State physicians" unless some better name can be found. This grade is to be open to all upon passing an examination before a Board appointed by the Governor. Entrance to it, he thinks, should be a prerequisite to holding public medical office, or to appearing in court as an expert witness. Other practitioners would not be interfered with and the people would enjoy the right to employ them, if they chose; but he thinks the

"State physicians" would soon stand so much higher with the people as to make it almost a necessity for a medical man, who would succeed in practice, to enter the more reputable class.

### Care of the Insane in New York.

The new law in New York for the care of the insane was signed by the Governor on April 15. By the terms of the act all the pauper and indigent insane in all the counties of the State, except New York, Kings and Monroe, will be cared for and maintained by the State without any charge or expense whatever to the counties. The number of insane affected by this bill is a little less than 2,300, less than one-half of the whole number now cared for by the State. No asylums are to be built, as the State had before the passage of the bill adopted plans for, and entered upon the construction of, buildings in which 1,600 of the number to be cared for can be accommodated, leaving only 700 to be provided for by the erection of small detached buildings on the grounds of the present State asylums, at a cost of $550 per patient, or $385,000 for the whole number. Hereafter no pauper or indigent insane person can be returned from a State asylum to a county asylum.—*Medical Record*, April 19, 1890.

### Red Nose.

In twenty per cent. of the cases of red nose the redness is caused by acne rosacea. Where rosacea is the cause, Unna gives one-half grain of ichthyol internally, and, at the same time, applies it externally in aqueous solution at night, or he prescribes the following sulphur-zinc paste as given in the *Chemist and Druggist*, May 31, 1890, to be applied nightly:

| | | |
|---|---|---|
| ℞ | Ung. zinci . . . . . | 20 parts |
| | Amyli oryzæ . . . . . | 5 " |
| | Sulphuris . . . . . | 2 " |

Later on, Unna has the enlarged venous trunks punctured with Hebra's instrument two or three times per week; the little wounds are immediately covered with wet cotton. For very mild cases and for supplementary treatment repeated washing with ichthyol soap is recommended, warm water only to be used, as in all cases of rosacea.

### Action of Tobacco on the Teeth.

Professor Miller, of Berlin, has found that, by boiling fifteen grams of Virginia tobacco in fifteen cubic centimeters of water, adding fifty cubic centimeters more of water to the filtered decoction, and mixing the whole with an equal quantity of saliva, the bacteria in the latter are not destroyed, but merely arrested in their development. On the contrary, when the smoke from a cigarette was made to pass through a culture-medium impregnated with salivary bacteria, the medium was completely sterilized. In view of these facts, it may be asked why smokers are not exempt from dental caries. The reason, Professor Miller says, is simply because tobacco smoke does not penetrate to the seat of the disease.—*Druggists' Circular*, June, 1890.

### Snuff for Colds.

The following is a convenient formula to be used in place of solution of cocaine:

| | | |
|---|---|---|
| ℞ | Sodii bicarb . . . . . | grs. ij. |
| | Magnesiæ carb. (Levis) . . . | " iij. |
| | Menthol . . . . . | " j. |
| | Cocain. hydrochlor. . . . . | " iv. |
| | Sacch. lactis . . . . . | ʒiss. |

M. Sig.: Use as snuff.

It is said that the most marked relief follows the use of this powder, and a few applications will do much to abort the catarrhal attack. Its effects are immediate, highly agreeable to the patient, and continue for a number of hours.—*Chemist and Druggist*, May 31, 1890.

### Some Antihydrophobic Herbs.

In the Ukraïne (South Russian) popular medicine the following plants enjoy the reputation of being good remedies for hydrophobia: *Euphorbia Peplis*, *Genista tinctoria*, *Alisma plantago*, *Origanum vulgare* and *Tanacetum vulgare* (tansy). In order to study the alleged remedial properties of these herbs Dr. Foma K. Alexëëff, of Kharkov, has carried out a long series of experiments on dogs, rabbits and guinea-pigs inoculated with rabies. The results proved to be totally negative, none of the herbs manifesting any slightest prophylactic or curative influence in regard to the disease.—*Vratch*, No. 13, 1890. [Anybody familiar with the history of the subject would not have wasted time over these experiments.—Ed. Reporter.]

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When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.
The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

## NOT BURIED ALIVE.

The fear of being buried alive haunts the minds of so many of our fellow-men that it may hardly be regarded as strange, in some respects, that it was recently reported that a number of physicians in a city near Philadelphia had banded themselves together to devise means to prevent such a catastrophe in their own case. And, when physicians could take such measures in view of a supposed danger, it is not remarkable that the community should have a special and exaggerated horror of being buried alive. But, this horror is as without reason as is the timidity of the physicians referred to. There seems to be no good ground whatever for supposing that it is possible in this enlightened age for any person to be committed to the grave while yet living. Stories reporting such occurrences are by no means rare; but any one who examines them closely will certainly remark that they are wholly lacking in originality, and that there is in fact so strong a resemblance between them as to excite the suspicion that one has been copied from another. Investigation will show, too, that this suspicion is a well-founded one; at least such has been the experience of the Editor of the MEDICAL AND SURGICAL REPORTER, who has for some years followed up every story of burial alive which came to his notice, and always with the result of learning that they were false or of failing to learn anything about their origin.

The most recent experience of this sort occurred in connection with a story published in the daily papers June 10, 1890, of a man who was said to have died and to have been buried alive in Chicago. After tracing the story from one point of the newspaper world to another, it was found to have originated in a Chicago paper, which said the man had been sent as dead from a hospital in that city on February 23, and that afterwards he had been buried, that the buriers had heard sounds like knocking on the coffin lid, but went ahead with the burial, and that after an interval the grave was opened and the coffin lid removed to disclose that the man had turned over, torn his hair out, buried his fingers in his flesh, and so on. At the end of our investigation we received a letter from the hospital stating that it never had a patient of the name given, that no person died in the hospital on the date given, and treating the story as a hoax. The Associated Press agent in Chicago who started the story round the country, on being asked if he thought there was any truth in it, replied to our representative: "I am not supposed to believe everything these fellows (meaning the reporters) write."

This is the latest story, and it illustrates the unreliability of all of them that we know anything about, and the utter lack of principle which usually lies at the bottom of them. As physicians we may, by publish-

ing the falseness of such stories, do something to allay the awful fears which they excite in the minds of many of our fellow-beings; and we may hope that those who manage the daily newspapers will some day properly punish reporters who furnish them with such cruel inventions.

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### DOCTORS AS DESTROYERS.

From the earliest period in the history of medicine physicians have been the subjects of witticisms which intimate that they have a double function: one to heal the sick and another to facilitate their exit from a world of woe. Juvenal said of Themison, a physician who practiced in the first century: "Quot Themison aegros autumno occiderit uno." Physicians do not, as a rule, mind this sort of a pleasantry; but, at bottom, they do not like it. This being the case, physicians should do nothing to encourage such jokes, and least of all should they go to killing their fellow-men in broad daylight, and with the full knowledge of the community. If they must kill them, it should be done in a manner least likely to do harm to the already delicate reputation of the profession.

We have no doubt the readers of the REPORTER will approve this suggestion, and that they will share with it the regret occasioned by a recent occurrence, in which a physician in Birmingham, Ala., not only shot a fellow-man but did it to a fellow-practitioner. More recently still—in fact in the latter part of June, this year—a Louisville physician went out to what is called ironically the "field of honor," with the apparent intention of putting a bullet through a farmer of that region. The fatal issue of the encounter was prevented by the good sense of the farmer, who at the last moment concluded that the game was not worth the candle, and that he would be a fool to run the risk of making his wife or that of his antagonist a widow.

We applaud the judgment of the farmer, for the Doctor might have killed him, and then the greater fool would have survived, and certainly the greater coward; for, as we understand, in Kentucky it takes a deal more courage to back out from a duel than to go into one.

As for the Doctor, we trust that he will never again put the profession in such a bad position before the eyes of the world. If he wishes to get even with any one who has expressed an unfavorable opinion of him he had better adopt those quiet and unconspicuous methods which were familiar to medical men and alchemists a few centuries ago. These are rather more effective than dueling, and when they were in vogue secured a vast deal of respect for those who availed themselves of them.

This little hint, we trust, will be taken with due discretion by the readers of the REPORTER.

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### SIGNIFICANCE OF DIFFERENCE BETWEEN TWO RADIAL PULSES.

One by one erroneous notions are corrected by more careful observation. From the time of Marey, whose name is inseparably connected with the sphygmograph, it has been the common belief that a difference between the two radial pulses in the same patient is highly significant of aneurism of the aorta, or of one of the great vessels coming off from it. It is true that in some cases of aneurism of these vessels the pulse in the affected side is felt to be retarded, and to differ in volume and in tension from that of the healthy side. The sphygmograph records much more accurately the condition; it shows a low, sloping up-stroke, a rounding of the summit, and a more gradual descent than in the pulse of the unaffected side, the tracing being wave-like. But it appears that this condition of the pulse, and the sphygmograph, which has been regarded as characteristic of aneurism, is not due to aneurism *per se*, that it may be present in the absence of aneur-

ism, and may not be present when aneurism exists. According to Von Ziemssen (*Deutsches Archiv. für klinische Medicin*, May, 1890), it is the result of a narrowing of the artery—innominate or subclavian as the case may be—and while it may occur in aneurism, as the result of pressure, for example, it is most frequently the result of arteritis deformans, an atheromatous condition of arteries which frequently results in narrowing of the vessel. Von Ziemssen gives brief notes of eight cases; in four of them the pulse-tracing which has been believed to be characteristic of aneurism was present, but there was no aneurism, the lesion, as proved by autopsy, consisting of a narrowing of the mouth of the subclavian artery as the result of arterio-sclerosis. In the remaining four cases, the pulse-tracing of the two radials showed no essential differences, but there were manifest physical signs of aneurism of the arch, such as pulsating tumor, paralysis of the recurrent laryngeal nerve, etc.; in one of these cases the diagnosis was established by autopsy.

The fact than stenosis of the great vessels may produce the difference in the pulses in question has not altogether escaped observation by other writers. Quincke hints at it, and Broadbent reports a case in which the lesion was actually discovered *post-mortem;* but he speaks of it as a "remarkable case." Arterio-sclerosis of the aorta is much more common than aneurism of the arch; it should, therefore, be very easy to confirm the statements of Von Ziemssen. The subject is of importance in prognosis as well as in diagnosis, and we hope it will receive attention on this side of the water.

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### POISON OF TYPHOID FEVER AND CHOLERA INFANTUM.

It was announced in the daily papers of July 7 that Dr. Vaughan, of Ann Arbor, had recently discovered the poison which causes typhoid fever and cholera infantum. There can be no doubt that Dr. Vaughan is not responsible for these statements in the form in which they appear. Our readers are aware that this is not the first time that the medical world has heard of the isolation of a ptomaine which Dr. Vaughan thinks may be the cause of typhoid fever, and as to the cholera infantum, it is hardly likely that Dr. Vaughan would make any such exaggerated claims for the poison which he has isolated, and with which he has experimented, as the newspapers do.

Still it cannot fail to interest the public at this season to hear that so able an experimenter has found something which seems to have a practical bearing upon the prevention or treatment of a disease which every summer carries off so many victims, and the readers of the REPORTER will await with equal interest the details and authorized account of what Dr. Vaughan has been doing, which gives rise to these sensational announcements.

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## BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

TEXT-BOOK OF MEDICAL CHEMISTRY. For Medical aad Pharmaceutical Students and Practitioners. By E. H. BARTLEY, B. S., M. D., etc. Second Edition. 8vo, pp. 423. Philadelphia: P. Blakiston, Son & Co., 1890.

This work has reached a second edition, which is a mark of a certain acceptation by the profession. But, as a text-book, it gives too much prominence to theoretical considerations to the exclusion of practical details. This is especially the case in the medical, physiological and pathological portions of the subject. The pharmaceutical portion is not open to the same objection. Usually in medical chemistries considerable attention and care are paid the various fluids of the body and the excreta, but Dr. Bartley does not, except in the briefest possible way, consider the urine, blood, bile, digestive juices, etc. In fact, the analyses of blood, bile, chyle, saliva, gastric and pancreatic juices, milk, tears and sweat are crowded into several tables of compilations in the appendix, and are elsewhere considered only as their important principles fall into the author's classification of organic substances. If the name of the work were not "Medical Chemistry," there would not be much in it to criticise, but as a medical work it is open to the serious objection of not being medical enough. Generally the author is clear except where he has had to sacrifice something to want of space The book contains a number of typographical errors, although the types are good and clear, and the binding is of fair quality.

## Literary Notes.

—We have received the prospectus of the *Biography of Ephraim M'Dowell, M. D.*, "the Father of Ovariotomy," which is shortly to be published by his granddaughter, Mrs. Mary Young Ridenbaugh. Besides an account of the life and work of Dr. McDowell, the book will contain several valuable articles relating to ovariotomy. The subject of the work will make the book one of interest to every physician, but especially so to every gynecologist. The authoress, Mrs. Ridenbaugh's work is endorsed by the most eminent medical men in this country and abroad.

It will be sold by subscription only. Those who desire the work should send their orders to the authoress and publisher, Post-Office Box 372, Philadelphia, Pa. The price ranges from $5 to $6, according to binding.

—A Newcastle-on-Tyne publishing firm, Messrs Mawson, Swan & Morgan, announces the fac-simile reproduction of an old manuscript volume entitled "Ye Apothecarie: his Booke of Recepts agaynste alle maner of sicknesses; allso howe to bake meates, to make Uskabaughe, to die clothe or woole, and divers usefull thinges besydes." The manuscript dates back about three centuries.

## Notes and Comments.

### Pathology and Treatment of Goitre.

In the *Birmingham Medical Review*, June, 1890, there is a paper by Dr. Berry, on goitre, of which the following summary appears in the *London Medical Recorder*, June 20:

Dr. Berry divides innocent forms of goitre into two classes—those in which the whole gland is more or less uniformly enlarged, and those in which the enlargement is due to the development of one or more definite cysts, or solid tumors, generally in one lobe only of the gland. The former is usually met with in young people, and may be regarded as the first stage in the development of nearly all goitres. The goitre consists in some cases of a mere hypertrophy of all parts of the gland, but in most the enlargement is due chiefly to increase in the amount of colloid material in the thyroid vesicles. Each vesicle, instead of containing a small amount of colloid material, as in the normal gland, is much dilated and contains a greatly increased amount of secretion. In fact it would be correct in most cases to look upon the enlargement as being due to a hypersecretion of colloid material into all the vesicles of the gland. There is also some increase in the connective tissue and glandular elements. That this hypersecretion is brought about, in the great majority of cases, by some material introduced into the body by means of drinking water, admits of but very little doubt. This form of goitre rarely produces any very serious symptoms, although sometimes these arise from, by pressure upon the trachea, recurrent laryngeal nerves, and other structures in the neck. Death may result from pressure upon the trachea. As a rule goitres involving the whole of the gland compress the trachea in such a manner as to cause lateral rather than antero-posterior flattening.

The operative measures for the cure of parenchymatous goitre, excluding injections, the use of setons and ligature of the thyroid arteries, which the author regards as worthy of discussion, are division of the isthmus with or without removal of a portion of it; resection as recently introduced by Mikulicz, of Cracow, which consists in removing all the goitre except a small piece on each side of the trachea; and extirpation of one half or more of the gland.

Division of the thyroid isthmus was first performed in this country by Mr. Holthouse, at the Westminster Hospital, in 1874; but for some years it attracted little or no attention until revived by Mr. Sydney Jones, of St. Thomas's Hospital, in 1883, since which it has been extensively practiced. Mr. Jones pointed out that the operation not only gave relief to the dyspnœa, but caused a remarkable diminution in the size of the goitre by inducing atrophy of the lateral lobes. Mr. Berry does not endorse the view that the relief to the dyspnœa is due to the mere mechanical separation of the two halves of the gland, but to the shrinking of the lobes which follows the operation, consequent on the oozing away of the viscid colloid secretion contained in the vesicles of the gland. He has noticed that division of the thyroid isthmus in truly fibrous goitre gives little or no relief to dyspnœa, and is not followed by diminution in the size of the growth as in the more common colloid variety. The relief afforded by the division of the isthmus in the colloid variety may be permanent, but frequently the goitre reappears when the wound has healed and the secretion is again pent up in the gland. In many cases where very urgent dyspnœa is present a mere division of the isthmus will not afford relief sufficiently quickly. It is then necessary to do some further operation, either tracheotomy or the removal of a considerable portion of the goitre, the latter being the more advisable.

Resection, as performed by the Polish surgeon Mikulicz, is particularly suited to parenchymatous goitre. He performs the operation in the following manner: He first isolates one lobe of the goitre in the ordinary way, as if he were about to remove it, but takes care to leave untouched the connections on the inner side where it is in contact with the larynx, trachea, and recurrent laryngeal nerve, and where the inferior thyroid artery enters. In this region a good-sized piece of gland—enough to carry on the functions of the organ—is left intact, all the rest of the lobe being cut away. The same proceeding is then executed, if necessary, on the other side of the neck. In this operation the dangerous region above mentioned is not interfered with, consequently there is no fear of injuring the recurrent nerves. The goitre is almost completely removed, but the small portions left behind obviate any danger of the supervention of cachexia strumipriva (so-called artificial myxœdema.) Twenty-three cases of this operation are reported in Langenbeck's *Archives* for 1888. In twenty the wound healed by first intention; in two, suppuration occurred which delayed the healing process; and one patient died from recurrent hemorrhage, the ligature having slipped from the superior thyroid artery.

The remaining operation, which may be performed in bilateral parenchymatous goitre, viz., removal of one lobe of the gland, is more easily performed than any operation by which large portions of both lobes are removed. It has the disadvantage, however, that the opposite lobe almost always undergoes some degree of subsequent hypertrophy, causing displacement of the larynx and trachea.

The second class, which may be termed unilateral goitres, never consist of simply hypertrophied gland tissue. The enlargement is due in all cases to the development in the gland of one or more distinct tumors, either cystic or adenomatous growths of some kind. They less often cause death by suffocation than do bilateral parenchymatous goitres. Still they are frequently a source of considerable inconvenience, and even of some danger, to the patient. Hence at times they call for removal, and this may be performed with very little danger. There are two methods of operating, enucleation and extirpation. The former consists of removal of the tumor alone from the interior of the gland, everything else being left behind, and is applicable only to those cases in which the goitre forms a well-defined tumor embedded in the gland. The latter consists in removing the whole of the affected lobe of the gland. The author gave details of cases in which he had operated for unilateral goitre by enucleation, and also one case of extirpation, the tumor weighing eighteen ounces, the results in each being satisfactory. The discussion of other methods of treating cystic goitre by tapping, injecting, etc., was outside the scope of the paper.

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### Nature of Leprosy.

The various theories which have been advanced from time to time to account for the production of leprosy, are discussed by Sir William Moore, K. C. I. E., whose experience among sufferers from the disease has been very considerable. Concerning the malarial theory, Sir William Moore is convinced that it does not afford any sufficient explanation of the etiology of the affection, and especially since leprosy is a prevailing malady in countries which are free from the so-called malariæ. In the same manner it is assumed that insanitary surroundings and absence of salt in food are not of themselves efficient factors in the production of leprosy, inasmuch as it is shown to occur freely among the denizens of carefully drained and cleansed quarters, though it is admittedly much more common among the poor and destitute; and also because it is constantly encountered among the inhabitants of semi-desert districts in Western India, the principal product of which is salt. The much-debated influence of a fish dietary in causing leprosy is discussed at some length, and it is shown that from various circumstances fish in any form is almost an unknown food in districts whose populations exhibit as large a proportionate number of lepers as is found among those living on the coast. To this effect also is the evidence afforded at a meeting of the Medical and Physical Society of Bombay, held last winter, and at which the subject of fish eating in relation to leprosy was brought under discussion. The speakers were generally agreed that no sort of connection existed between the two, and this view seems now to be pretty universally accepted by those who possess opportunities of observing if such a relation has any existence in fact. The theory to which Sir William Moore inclines, and the enuncia-

tion of which is the real object of his paper, is that leprosy is a phase of inherited syphilis, and he offers replies to the principal objections raised against the acceptance of that view which regards the two diseases as of similar nature. The many remarkable characteristics shared in common by leprosy, tubercle and syphilis, have for long past excited the attention of scientific surgeons, and the well-known labors of Mr. Jonathan Hutchinson on the connection between the first of these diseases need only be referred to in proof. Respecting the possibility of leprous subjects contracting syphilis, which has been urged as a reason against the identity of the two affections, Sir William Moore says that he has never seen such a case; but he adds that even a Hunterian chancre may very exceptionally be twice developed on the same person; syphilis arising in a leper would be comparable to it. Though it can hardly be said that the author advances anything that is absolutely new in his paper, yet he lends fresh emphasis to several points which will well bear careful reconsideration, and especially just now that special attention is being devoted to the discovery of the actual *materies morbi* of various ill-comprehended diseases. Leprosy as a wide-spread contagious disease, the victims of which are debarred from ever anticipating a cure of their condition, must command and will receive unceasing study so long as it proves the *opprobrium medicorum* that it is at present.—*London Med. Recorder*, June 20, 1890.

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## The Grippe and Cholera.

Fears having been expressed as to a possible connection between influenza and cholera epidemics, Dr. Smolenski publishes, in the Russian *Official Messenger*, an elaborate report upon the subject. He points out that the suspicion is not new, and that in 1837 it was discussed by Gluge ("Die Influenza"), and refuted. In fact, influenza or *grippe* epidemics have been known in Europe since 1173, that is, for more than seven hundred years; while the first cholera epidemic appeared in Europe in 1823, but did not spread that time farther than Astrakhan. Six years later it broke out in Orenburg; next year, in Caucasia and Astrakhan again, whence it spread over Russia, and in 1831 reached western Europe. As a rule, influenza spreads very rapidly; and at St. Petersburg in 1782, says *Nature*, no fewer than forty thousand persons fell ill of it on the same day (Jan. 14). In 1833 its progress was also very rapid, and within a few days it appeared at places so far apart as Moscow, Odessa, Alexandria and Paris: while cholera epidemics are usually slow in their migrations from one place to another. Moreover, influenza is chiefly a winter epidemic, while cholera prefers the spring and the summer.

Dr. Smolenski has further tabulated all influenza and cholera epidemics which have broken out in the course of this century in Europe; and he comes to the following results: influenza broke out in 1816 in Iceland; 1827, in Russia and Siberia; 1830–33, in Europe generally; 1836–37, in Europe; 1838, in Iceland; 1841–48 and 1850–51, in Europe; 1853, in the Faroe Islands; 1854–55 and 1857–58, in Europe; 1856, in Iceland and the Faroe Islands; 1862, Holland and Spain; 1863–64, France and Switzerland; 1866, France and Great Britain; 1867, France, Germany and Belgium; 1868, Turkey, and 1874–75, western Europe. As to the cholera epidemics during the same period, they were, 1823, Astrakhan and Caucasia (from Persia); 1829, Orenburg (from Turkestan); 1830, Russia (from Persia); 1831–37, various parts of Europe. The next epidemic appeared in 1846 in Transcaucasia (coming from Persia); in 1847 it spread over Siberia and Russia, and in 1848 it was in Europe; in 1849–52 it was followed by feeble outbreaks all over Europe. The third cholera epidemic came from Persia again in 1852, and it resulted in a severe outbreak during the years 1853–55 in Europe, followed by feebler outbreaks till 1861. The fourth cholera epidemic came through the Mediterranean ports in 1865, and lasted in Europe till 1868, with feebler epidemics in 1869–74. The latest invasion of cholera was in 1884, when it came again through the Mediterranean ports. As to the cholera epidemic which now begins to die out in Persia and Mesopotamia, it certainly is a danger; the more so, as, out of the five epidemics of cholera which have visited Europe, three have come from Persia.—*Science*, February 14, 1890.

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## Nerve Nævi.

At the meeting of the Medical Society of Hamburg, January 28, 1890, Unna presented a case of so-called nerve nævi in a

child five years old. This affection is exceedingly rare. Unna says (*Deutsche medicin. Wochenschr.*, June 5, 1890) that only three cases have been described thus far, one under the name of ichthyosis linearis neuropathica. It is characterized by lines running from the upper gluteal region over the popliteal space, down the calf and along the inner side of the tendo Achillis, over the dorsum of the foot to the small toe. In the upper portion the lines are made up of flat papules, in part covered with scales. Lower down they are made up of skin in a condition of hyperkeratasis (hypertrophy of the epidermis). In the case presented, the affection began in the child's second year, and, barring slight fluctuations, has been constant. The skin of the parts affected has grown more dry. Unna rejects the idea of any association of the manifestations of the disorder with disease of the peripheral nerves, as the course of the lines does not correspond with that of any particular nerve. He would rather believe in a connection with the embryonal fissures.

The term "nerve nævus, or papilloma neuropathicum," is usually defined as meaning a nævus corresponding in location to the area of distribution of one or more cutaneous nerves. If the view of Unna, stated above, is correct, the name is not well chosen. We will look with interest for further facts in regard to this curious affection and hope that a more appropriate name for it will soon be suggested.

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## Accidental Rectovesical Lithotomy.

At the last meeting of the Medical Society of North Carolina, Dr. O'Hagan reported a very unusual operation which was performed by accident while doing another one.

He presented a calculus 3½ inches long, 3 inches wide and 1½ inches thick and weighing 7¾ ozs., and gave the following brief description of the case. The patient came to him, a lean, cadaverous fellow, last July, and asked him if he could do anything for paralysis. On being answered in the negative, he started to leave in great despair. Calling him back, Dr. O'Hagan examined the bladder, discovered the presence of a calculus which he supposed to be about an inch and a half long, and told the man he could get relief only by an operation. The man consented, and, after a few days of preparatory treatment, was operated on. The main reason in reporting the case was to warn others against too careless examinations in these cases as to the size of the stone. He made two examinations, but not as careful ones as he should have made, and was dumbfounded when he found he could not extract the stone through the perineal opening. A young medical friend came to his assistance, and in working at the stone with a pair of forceps, succeeded in pushing the forceps through the vesico-rectal septum.

The operation was done a week before last Christmas. Dr. O'Hagan did not think the patient could stand an extra supra-pubic lithotomy, so sent him home. To his very great surprise the patient did well, and the wound in the perineum healed kindly. Dr. O'Hagan then concluded to try to remove the stone through the rent in the bladder, and the man being anæsthetized, the sphincter was stretched and the stone was found presenting at the recto-vesical opening. It was removed with very little trouble, and the opening has decreased to a small fistula which will require an operation. The patient was thirty-eight years old, and had been suffering from infancy.

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## Vaginal Hysterectomy.

At the recent meeting of the American Medical Association, Dr. Franklin H. Martin, of Chicago, read a paper the title of which was "A Plea for Early Vaginal Hysterectomy for Cancer of the Uterus." Dr. Martin had collected 134 cases of vaginal hysterectomy, which had been performed since January 1, 1885, with the idea of getting at the immediate mortality of this operation. He received replies from twenty-five prominent operators, representing 134 operations. The mortality was less than 15 per cent. Of the twenty-five operators four had operated but once; three, twice; two, three times; three, four times; five, five times; one, eight times; one, twelve times; one, thirteen times; and one, twenty times.

The average mortality of the operators having the greatest number of cases was but ten per cent. The operator having the greatest number of cases has also the smallest mortality, the mortality being but five per cent. The operator having the next highest number of cases has also the next

lowest mortality, the mortality being 6.6 per cent.

Dr. Martin concludes that vaginal hysterectomy is the most justifiable surgical procedure we yet know of for cancer of the uterus; and it should be attempted for the cure of cancer of the uterus at the earliest possible moment after the disease is diagnosed.

The following facts were given in support of the foregoing propositions: Vaginal hysterectomy will remove the whole of the diseased tissue in cancer of any portion of the uterus in a greater proportion of cases than will any other surgical procedure now recommended. For cancer of the uterus, it will enable an operator to go further beyond the diseased tissue into healthy tissue than will any other surgical procedure. It is a more ideal surgical operation, and leaves the remaining tissues in a less favorable condition for the return of the disease than will any other surgical procedure. It will give in the future an immediate mortality among general operators of not more than ten per cent.; while in the hands of experts the mortality will not exceed five per cent.

## Abdominal Surgery and Its Responsibilities.

At the recent meeting of the American Medical Association Dr. Thomas H. Manley, of New York, read a paper in which he says that surgeons should always proceed with caution when they contemplate an operation which involves an abdominal section; and that the unfortunate statistics of interference in penetrating or gun-shot wounds of the abdomen must not be unheeded, and operators should proceed slowly with exploratory incisions until the art of diagnosticating and localizing lesions within the peritoneal cavity has reached greater perfection than at present obtains.

He thinks that the varied, modern tests of intestinal laceration possess no substantial use, and that surgeons are yet without means of determining with accuracy whether or not the intestinal tube has been penetrated; or where, or to what extent.

Although anæsthesia and antiseptics have been of great value in the progress of surgery, it seems that our position in dealing with traumatic lesions within the abdomen is but little in advance of that of the 18th century.

Dr. Manley says the notion cannot be too strongly combatted that surgical treatment is the *only* one for ailments which arise from pathological changes in the uterine-adnexa; and that it cannot be too strongly emphasized that recovery from operation is not a cure in any sense. Further, we must regard many of our modern operations, involving the peritoneum, as not only reckless mutilations, but as vicious and unnecessary interferences followed by serious consequences to the patient.

## Baccelli's Mixture.

According to the *Deutsche med. Wochenschrift*, June 5, 1890, Mistura Baccelli, useful in malaria, has the following formula:

| | | |
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| ℞ | Quininæ sulphatis . . . . . | gr. xlv |
| | Ferri et potassi tartratis . . . | gr. cv |
| | Aquæ destillatæ . . . . . | f℥x |
| | Liquoris potassi arsenitis . . | gtt. xxv |
| M. | Sig. One to three tablespoonfuls daily. | |

If in severe cases other modes of absorption are not available Baccelli makes intravenous injection of quinine:

| | | |
|---|---|---|
| ℞ | Quininæ hydrochloratis . . . | gr. xv |
| | Sodii chloridi . . . . . | gr. xij |
| | Aquæ destillatæ . . . . . | ℥iij ℥ij |
| M. | | |

## The Muzzle as a Protection Against Rabies.

The *British Medical Journal*, June 14, 1890, says: The statements of all the experts affording evidence of any real value all go to show the supreme importance of the muzzle as an agent for the suppression of rabies. The official returns from Berlin, when taken in their entirety, prove the case for the muzzle up to the hilt. The outbreaks referred to were traced to laxity of the police regulations, caused by years of practical immunity from rabies following upon prolonged periods of muzzling. Above all the report of the Select Committee is of the highest value, because, after having heard and examined all the witnesses for and against muzzling, the Committee reported first and foremost that when rabies is prevalent the muzzle should be enforced. After so conclusive a verdict being delivered by those specially appointed to consider the evidence, it is difficult to understand the frame of mind of those who seek to re-try

the case in the absence of the witnesses. If medical men do not necessarily understand the question of rabies in dogs it may at least be assumed that editors of canine journals do, and one need only refer to the columns of the *Stock Keeper* and the *Fanciers' Gazette* during the past three years to see that the experience of Berlin is regarded as being particularly instructive, and that muzzling regulations in various parts of the world have been in the highest degree beneficial.

## Pyoktanin.

In regard to pyoktanin, a new germicide (the word means "pus-killer") the *American Druggist*, June, 1890, says that recently Professor Stilling, of Strasburg, discovered the fact that certain aniline colors are capable of destroying bacteria in the living organism. He has examined a large series of these bodies, and finally selected two which possess the desired properties in a high degree. There is one drawback connected with them, however, namely, that they are strong coloring agents. On the other hand, they are non-poisonous, odorless, and far exceed bichloride in their antiseptic effects. They not only prevent, but also arrest all pyrogenic processes, and promote the healing of wounds and sores.

The apparent drawback of the tinctorial power of the agent is overbalanced also by the fact that the surgeon can the more easily control and insure its application to the parts requiring treatment. Any stains produced by pyoktanin in places where it is not wanted may readily be removed by Javelle water or alcoholic solution of soap.

There are, for the present, two kinds of pyoktanin in the market, one being blue (Pyoktaninum cæruleum) and the other yellow (Pyoktaninum aureum.) The former is more specially intended for general surgical, and the latter for ophthalmological, purposes.

Pyoktanin is used (in both colors) in form of dusting powder (2 per cent. and 1 per cent.), salve, pencils, troches for making solutions, and fabrics impregnated with 1 per cent. of the agent.

## Inoculation in the Future.

A writer in the *Hospital* says: "It is a dreadful point about these microbes that the only way to avoid having them in a virulent form is to have them in an artificial or attenuated form. The children of the future will not run through the present gamut of infantile disease, but they will probably be subjected to inoculation with various microbes every few months. First, they will be vaccinated for small-pox; when they have recovered from that they will be taken to a Pasteur institute to have a mild form of rabies. Next, they will be given a dose of the comma bacilli to prevent cholera, and so on through all the ever-growing series of disease microbes. Oh! luckless child of the future! you will never be ill and never be well; your health will be awfully monotonous; you will never know the weariness of the first night of measles, when it was so nice to lie in mother's lap and feel her cool hand on your forehead; you will never know the joys of convalescence, when oranges were numerous and every one was kind to you because you were not well; and your end will be to die of debility. How glad we are that we live in the present, with all its ups and downs of health to lend variety to life and death. — *Druggists' Circular*, May, 1890.

## Death from Rattlesnake Bite.

The Philadelphia daily papers of July 14 report a presumable case of death from the bite of a rattlesnake. On July 13 a woman's body was found in the woods near the village of Foster, Pa. The body was almost unrecognizable, but proved to be that of a woman who had left her home in Foster about two o'clock in the afternoon to pick raspberries. She had been bitten by a rattlesnake and her body was swollen to unnatural proportions. The marks of the snake's fangs were visible on her arms.

## Licorice to Mask the Taste of Quinine.

Of the following preparation it is said that one dram will mask the taste of about three grains of quinine, the results from its use showing it to be much superior to yerba santa and saccharine.

| | | |
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| ℞ | Dry licorice extract . . . . . | 20 parts |
| | Hot water . . . . . | 10 to 20 parts |
| | Glycerine . . . . . | 20 parts |

Dissolve and let cool, and to the solution add alcohol ten parts and distilled water sufficient to make eighty parts.

### Injection for Fistula.

The following injection is, according to the *Medical Press and Circular*, April 30, 1890, much used for fistulous tracts in one of the principal hospitals of Paris:

℞ Camphor . . . . . ℥j
Salol . . . . . ℥ss
Ether . . . . . f℥j
M.

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### Treatment of Scabies.

According to the *Medical Press and Circular*, April 30, 1890, the following formula is employed at the St. Louis Hospital, Paris, in the treatment of scabies:

℞ Oil of sweet almonds . . . . . f℥iii
Salol . . . . . ℥i

M. Sig.—Anoint the body with this mixture every night and then rub lightly with flowers of sulphur.

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### Sanitarium for Consumptives.

By the will of Miss Mary A. Edson one thousand dollars was recently left to the Adirondack Cottage Sanitarium provided it continues as a charitable institution.

This Sanitarium is for consumptives who are not considered incurable. It is beautifully situated on the side of a hill. It is a group of cottages which cluster round the main building. Each cottage accommodates from two to four patients, who each have a separate bedroom opening off the central sitting room, common to all. The charges made do not cover the expense of boarding the patients, and yet include everything the patient wants, not only in the way of board and lodging, but also in medicines and medical attendance. Dr. Trudeau, of Saranac Lake, is in charge of the institution.

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### NEWS.

—The birth of a child weighing about twenty-five pounds was reported in Philadelphia, June 10.

—Steps are being taken by the Russian Health Society to organize a hygienic exhibition in Russia.

—The birth of a doubled-headed human monstrosity is reported from Trenton, N. J., under date of July 6

—Dr. William H. Ford was unanimously re-elected President of the Board of Health of Philadelphia, on July 8.

—There are said to be 40,321 medical practitioners in Japan. The population is estimated at about forty millions.

—The honorary degree of LL. D. has been conferred by Lafayette College on Dr. Ezra M. Hunt, of Trenton, N. J., and by Yale University on Dr. Francis Delafield, of New York.

—Dr. David E. Gardiner, a well-known homœopathic physician, died in Philadelphia, July 10, 1890. Dr. Gardiner was graduated from the Homœopathic Medical College in 1857, and began his practice in Bordentown, N. J.

—Application has been made for a charter for a Hospital for Consumptives in Philadelphia, to be called the Rush Hospital. A very strong list of trustees is named and the medical staff is to consist of well-known physicians of Philadelphia.

—The Jersey City Health Board has taken the same doubtful course as was followed by the Baltimore Health Board ten years ago, in determining to use its own estimate of population in calculating the death-rate instead of the census enumeration.

—The *Norristown Herald*, July 2, contains a notice of the death of Miss Corson, daughter of Dr. J. R. Corson, U. S. A., due to an accident upon the railroad near Missoula, Idaho, a few days before. Miss Corson was the granddaughter of Dr. Hiram Corson, of Conshohocken.

—A preliminary injunction in a suit against the Medico-Chirurgical Hospital of Philadelphia, was granted July 5, to prevent the extension of the Hospital property with windows overlooking the plaintiff's premises. The Hospital has recently purchased several properties and it is their intention to build an extension.

—Medical students in London have been compelled to go through a course of four years' study, hospital attendance and lectures before being qualified to appear for the final examination. By an order of the General Medical Council of England, issued last month, the term of preparation has been extended to five years.

—On June 20 the foundation-stone of the main building of the Emperor and Empress Frederick's Children's Hospital at Berlin was laid in the presence of the Empress Frederick. Professor Virchow, in the name of the Committee, thanked that lady for her unremitting labors on behalf of the new institution, towards the cost of which she had collected about $100,000.